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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

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VS A15 (4) 15M 9/5B

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CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

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11221

	11944	021(111110)				Reg. Dist. I	No.
1. PLACE OF DEATH a. COUNTY	Carroll	MARYLAND	2. USUAL RESIDEN o. STATE Marylar		ed lived. If institution b. COUNTY	an: Residence b	/
RURAL and give		c. LENGTH OF STAY IN 16 4 years 25 da		VN (If autside carp Balti	orate limits, write R	~	nearest tawn)
OR INSTITUTION	PITAL (If nat in haspital, give str	eet address)	d. STREET ADDR			J V 0	e. IS RESIDENCE ON A FARM? YES NO
3. NAME OF DECEASED (Type ar print)	First Edith	Middle	les) Beard	4. DATE	Mon		Doy Year 3 19 5
5. SEX Female	Tellos + o	ARRIED NEVER MARRIED DIVORCED DIVORCED	8. DATE OF BIRTH 3-6-1911		9. AGE (In years last birthday) yrs.	IF UNDER 1 YE Manths Day	EAR IF UNDER 24 HR ys Haurs Min.
10a. USUAL OCCUPAT during mest of wo WELGET	TION (Give kind of work dane 1 prking life, even if retired)	0b. KIND OF BUSINESS OR INDU		(State or foreign	country)		OF WHAT COUNTRY
13. FATHER'S NAME Charl	es Tyles		14. MOTHER'S MA	Patecek			14
15. WAS DECEASED EV (Yes, no, or unknown)	VER IN U. S. ARMED FORCES? (If yes, give war or dates of service)	10. 50 €17.10 5€ €5.1111 1101	INFORMANT Springfield	i State H	Add Hospital F		
	EATH [Enter only one cause pe EATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Brain Tumor.					NTERVAL BETWEEN ONSET AND DEATH 10 years
237; Canditians, if	(D)						10 months 18 days
gave rise to cause (a), statin lying cause last	g the <u>under-</u> DUE TO						
5 neoplasm	with psychotic					ZEN IN PART 1(c	19. WAS AUTOPSY PERFORMED? YES NO
OR CONTRIBUTION	G CAUSE OF DEATH FY MEDICAL EXAMINER)	DESCRIBE HOW INJURY OCCURRE	D. (Enter nature af in	jury in Part I ar Pe	art II af item 1B.)	Table 1	
20c. TIME OF INJU Haur a. m p. m	. WI		LACE OF INJURY (Ham actory, street, affice blo		ty ar tawn)	(Caur	nty) (State
	that I oftended the dece ctoper 3	eased from December 9,59, ond that death	occurred at 4:	30AM, from		d on the do	sow the decease ote stoted obove DATE SIGNE
PHYSICIAN'S NAME (Type)	Jøse Flores, N	1.D.	Sykes	sville, M			
220. BURIAL, CREMAT REMOVAL (Specif BURIAL	10-8-59	22c. NAME OF CEMETERY C		Ba	ATION (City, tawn, ltimore	or county)	(State)
23. FUNERAL DIRECTO		ADDRESS 217 St. Paul St:	reet	a. RECID BY REGI	518AR 24b. REGI	STRAR'S SIGNA	TURE

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VS A15 (4) 15M 10/57

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MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18 11245

CERTIFICATE OF DEATH

Reg. Dist. No.

11222

1. PLACE OF DEATH O. COUNTY CARROLL MARYLAND	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE b. COUNTY ARROLL
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest Jown) UNION BRIDGE RURAL VEARS	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) UNION BRIDGE RURAL
d. NAME OF HÖSPITAL (If not in hospital, give street oddress) OR INSTITUTION	d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES NO
3. NAME OF DECEASED (Type or print) (ATHER/NE MARIE	BLAKK 4. DATE Month Day Year DEATH OCT / 1959
5. SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED	B. DATE OF BIRTH DEC 4-1925 9. AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE OWN HOME	MARYLAND USA
JACOB ALTVATER	14. MOTHER'S MAIDEN NAME LYDIA STAUB
15. WAS DECEASED EVER IN U. S. ARMED FORCES? Ites no. or unknown) (If yes, give wor or dates of service) 2/3-24-9/43 O	RVILLE BLACK UNION BRIDGE MO
PART 1. DEATH WAS CAUSED BY: 153.9 Conditions, if ony, which gove rise to immediate couse (a), stoling the under lying couse lost. (b) DUE TO (c)	noma Mestine 3 ys-
CATIC	T NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPSY PERFORMED? YES NO 10. (Enter nature of injury in Port 1 or Port 11 of Item 18.)
20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e. PL	ACE OF INJURY (Home, form, 20f. (City or town) (County) (State)
21. I certify that I attended the deceased fram.	occurred at // PM, from the causes and on the date stated above ADDRESS (Street, city or town style) M.D
PHYSICIAN'S THILEGO	UNION BRIDGE
220. BURIAL CREMATION, 22b. DATE THEREOF 22c. NAME OF CEMETERY O BURIAL Specify) OCT 4-1959 ROCKY RIL	DGE ROCKY RIDGE MO
23. EUNERAL DIRECTOR'S SIGNATURE ADDRESS Bridg	e Md DATE OCT & 59

PARYLAND STATE ENGARGMENT OF MEATING SALTIMANT

1	, 1		MARYLAND STATE DEPARTM	MENT OF HEALTH—BALTIMORE, 18
ion,	-		11246 EXAMINER	'S CERTIFICATE OF DEATH Reg. Dist. No. 11223
Grema			PLACE OF DEATH O. COUNTY CARROLL MARYLAN	2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) o. STATE MARYLAND b. COUNTY CARROLL
o burial,	1	6	c. CITY OR TOWN (If outside corporate limits, write RURAL ond give nearest lown). WINTON BRIDGE VEARS	c. CITY OR TOWN (If outside corporate limits, write RURAL and give necrest town) UNION BRIDGE
Dia dia	X	d	I. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)	d. STREET ADDRESS o. IS RESIDENCE ON A FARM? YES \(\) NO
yaur fi		- 4	NAME OF DECEASED (Type or print) ROGER THOMAS	BOONE 4. DATE Month Day Year OF DEATH OCT 9 1959
ined for ith the r		5. \$	6. COLOR OR RACE 7. MARRIED NEVER MARRIED WIDOWED DIVORCED	8. DATE OF BIRTH 9. AGE (In years lead birtheday) NOV 6-1902 9. AGE (In years lf UNDER 1YEAR IF UNDER 24 HR. Months Days Hours Min.
be retained 2 w		10a.	. USUAL OCCUPATION (Give kind of work done lob. KIND OF BUSINESS OR INDU- luring most of working life, even if retired) IPHOLSTER RAILROAD	ISTRY 11. BIRTHPLACE (Stote or foreign country) 12. CITIZEN OF WHAT COUNTR 13. CITIZEN OF WHAT COUNTR 15. CITIZEN OF WHAT COUNTR
poges 1 c		13.	HANSON BOONE	SARAH WELKER
File	1		WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. 10. or unknown) 10. 5-10-6020	NOTH BOONE UNION BRIDGE MD
form PM3.	-		18. CAUSE OF DEATH [Enter only one cause positive for (o), (b), and (c).] PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o)	would abdone min.
alang with burial-trans			Conditions, if ony, which gove rise to immediate cause (o), stating the underlying couse tost.	
s Office	0	CATION	PART II. OTHER SIGNIFICANT CONDITIONS <u>CONTRIBUTING TO DEATH</u> BUT	T NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) 19. WAS AUTOPSY PERFORMED? YES \(\sum_ \text{NO} \) NO \(\sum_{\text{N}} \)
Examiner's hauld be us		CERI	CAUSE OF DEATH. Surehal wo	, the second of
E E		3	20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e. Pt	LACE OF INJURY (Home, form, 1206 (City or town) (County) (Stole)

21. I certify that I took charge of the remains described above, held an Autopsy ...

While Not while of work

22d. LOCATION (City, town, or county)

(Stole) Inquiry and find that

ER 24 HRS. Min. COUNTRY?

Inspection Undetermined cause death resulted from: Natural causes [], Suicide X,

ACTUAL

CHIEF MEDICAL EXAMINER

ASSISTANT MEDICAL EXAMINER DEPUTY MEDICAL EXAMINER

DATE SIGNED (Stote)

220. BURIAL, CREMATION, REMOVAL (Specify)

22c. NAME OF CEMETERY OR CREMATORY ADDRESS

24a. REC'D BY REGISTRAR

24b. REGISTRAR'S SIGNATURE

NAME (Type)

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VS. A15ME(5) 5M 9/55

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	E OF DEATH	S GERTIFICAT	EXAMINER	پ	
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		SE 1/4/37			a Track of the

ET BEDARTIES STIARE OF T

he funeral director, shauld be

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours ofter death. Page 4

may be retained by the hospital or attending physician.

TO FUNERAL FOCTOR: After this certificate has been signed by the attending physician and campletely filled in page 3 shaw. I detached far use as the burial-transit permit. Then please remove carbon papers. Pages 1 and the registrar prior to burial, cremation, ar remaval, and in any event within 72 haurs after death.

VS A15 (4) 15M 9/58

filed with

11224

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CEPTIEICATE OF DEATH

Rea.	Die	MI-
Reg.	DIST.	140.

	11247	CERTIFIC	AIL OF DEATH		Reg. Dist. No.
1. PLACE OF DEATH o. COUNTY	Carroll	MARYLAND	o. STATE Mary]	Land b. COUNT	Balto.City
b. CITY OR TOWN RURAL and give of Sykesvi	(If outside corporate limits, write nearest town)	5yrs.lmo.18da			RURAL and give nearest town) 3001.4
OR INSTITUTION	ITAL (If not in hospital, give streeteld State Hospi		d. STREET ADDRESS 2631 Hol	lins Ferry R	e. IS RESIDENC ON A FARM YES NO
3. NAME OF DECEASED (Type or print)	Nellie	Middle Tayman			onth Day Year
5. SEX Female	270 04	RRIED NEVER MARRIED DIVORCED DIVORCED	8. DATE OF BIRTH July 10, 187	9. AGE (In year last birthdoy)) Months Days Hours Mi
10a. USUAL OCCUPAT during most of wo Machine	ION (Give kind af work done 10 rking life, even if retired) WORKER	b. KIND OF BUSINESS OR IND Unknown -	USTRY 11. BIRTHPLACE (State of Maryland	r foreign country)	12. CITIZEN OF WHAT COUNT
13. FATHER'S NAME Edward T	armon		14. MOTHER'S MAIDEN NA		
		6. SOCIAL SECURITY NO.	INFORMANT Springfield H	Ac	ddress
C.B.S.as 20g. ACCIDENT W OR CONTRIBUTION (IF EITHER, NOTIF) 20c. TIME OF INJUITHOUT a. m. p. m. 21. I certify t	immediate at the under but to	INJURY OCCURRED 20e. Instrument of the last wark occurs occurs on the last wark occurs of the last wark occurs of the last wark occurs of the last wark occurs on the last war	DI NOT RELATED TO THE TERMIND	lerosis with ort or Part of item 18.) 20f. (City or town) ober 21, 1959	
PHYSICIAN'S NAME (Type) 220. BURIAL, CREMATI REMOVAL (Specify	Agustin delCs	22c. NAME OF CEMETERY		e, Maryland 22d. LOCATION (City, town	n, or county) (State)
Burial 23. FUNERAL DIRECTO	10/24/59	St. Peter ADDRESS ADDRESS		Balto Md. By REGISTRAR 24b. REG 2 3 '59 C.	GISTRAR'S SIGNATURE

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MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18 11248 **CERTIFICATE OF DEATH**

11225

Reg. Dist. No. 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE
b. COUNTY b. COUNTY MARYLAND Maryland Balto City

0.	COUNIT	Carroll		MARYLAN	D	o. SIAIE Mary	land	b. COUNTY	Bal	lto.	City	Y
b.		/N (If outside corporate lim	its, write	c. LENGTH OF STAY IN 1	Ь	c. CITY OR TOWN (If	outside corpo	prote limits, write R	URAL ond	give nec	rest town	1)
	KUKAL ond gi	Sykesville		2yrs.5mos.16	Sday	s Balti	more (5	3 VO	1-	4	
d.	NAME OF HO	OSPITAL (If not in hospital,	give street	oddress)		d. STREET ADDRESS					e. IS RES	IDENCE FARM?
	OK INSTITUTI	Springfield	Stat	e Hospital		5709 Be	lair I	Rd.				NOT
DI	AME OF CEASED (pe or print)	Jose	phin	Middle		lost Burns	4. DATE OF DEATH	Mon Octobe		30	,	Yeor 19 59
5. SE	x		*	RIED NEVER MARRIED	B. D	DATE OF BIRTH		9. AGE (In years	IF UNDER	1 YEAR		
1	emale	White	WIDOW			lay 30, 1892		lost birthdoy) 7 yrs.	Months	Days	Hours	Min.
10a.	JSUAL OCCUP	ATION (Give kind of work	done 10b.	KIND OF BUSINESS OR IN	IDUSTRY	11. BIRTHPLACE (Stote	or foreign o	country)	12. CIT	IZEN OF	WHATC	OUNTRY
	fusic t	working life, even if retired eacher	,	-		Maryland	l			U.S	.A.	
13. F	THER'S NAME				1	4. MOTHER'S MAIDEN	NAME					
I	Henry B	urns				Mary Ann	Mitche	el				
	No DECEASED	OEVER IN U. S. ARMED FOR		SOCIAL SECURITY NO.		rmant ringfield H	lospit	al Record				
1	8. CAUSE OF	DEATH [Enter only one co	use per li	ne for (o), (b), and (c).]		725577		/1		INTE	RVAL BE	TWEEN
	PART I.	DEATH WAS CAUSED BY:	Ar	teriosclerot	ic c	ardiovascul	ar di	sease		UNS	Year	rs
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	Conditions,	if ony, which) (b	Ge	neralized art	teri	osclerosis					Year	rs
	-	ting the under-						1000				
	lying couse I		:)									
CERTIFICATION	C.B.S.	other significant con assoc.with c psychot:	lrc.d Lc re	CONTRIBUTING TO DEATH IST, WITH CELL action.	rebr	related to the Jerm	inal diseas	sis with	EN IN PAR	T 1(o) 1	9. WAS PERFO	AUTOPSY RMED?
	OR CONTRIBUT	T WAS UNDERLYING [] TING [] CAUSE OF DEATH TIFY MEDICAL EXAMINER)	20b. DES	CRIBE HOW INJURY OCCU	RRED. (E	Enter noture of injury in	Port 1 or Por	rt II of item 18.)				
MEDICAL	Hour o.		ar 20d. 1 While of wor	Not while	. PLACE foctory	OF INJURY (Home, form, street, office bldg., etc	n, 20f. (Cit	y or town)	(1	County)		(Stote
1	1. I certify	that I attended the	deceas	ed fram Novembe	er 1	1, 19 58, to Oc	tober	30, 19 59	that I la	ist sav	v the d	ecease
	live an O	ctober 30,	, 195	2, and that de	ath ac	curred at 9:001	M, fram	the causes an	d on the	e date	stoted	above
1	CTUAL	9/7-11-01	14	agro 1110.		Canda -64	· ·	itreet, city or town,		7	- 1	/59
S	IGNATURE	1 conceses	2	1	M.D	Springfi	era 2	vave nosp	1 tal	1	0/ 2T	127

PHYSICIAN'S NAME (Type)

Sykesville, Maryland

Francesco Magro, M.D. 220. BURIAL, CREMATION, REMOVAL (Specify) 11-3-5 Baltimore, Md. 22c. NAME OF CEMETERY OR CREMATORY
New (athedral (New em.

Leonard J. Ruck 5305 Harford Rd.

24a. RECYDOBY REGISTRAS NOV 3 DATE

24b. REGISTRAR'S SIGNATURE

(Stote)

TO FUNERAL P page 3 shaw TO HOSPITAL VS A1S (4) 1SM 9/58



RILLAND STATE OES ATMINISTED HEALTH PEALTONOUT TO

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The second of	Department of the Control of the Con	Allenda	100 Maria 200 (200 Maria)

22c. NAME OF CEMETERY OR CREMATORY

NE

ADDRESS

5 haspital D FUNERAL page 3 shau 0 VS A15 (4) 15M 9/S8

death.

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death

23. FUNERAL DIRECTOR'S SIGNATURE

1650 YORKRI

24g, REC'D BY REGISTRAR

24b. REGISTRAR'S SIGNATURE

104/SWYDATEDCT 2 2 '59

(Stote)

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 1 Film G251 11-13-59 et

CERTIFICATE OF DEATH

11251	CERTIFICA	ATE OF DEATH	Reg. Dist.	11228
1. PLACE OF DEATH 6. COUNTY Carroll	MARYLAND	2. USUAL RESIDENCE (Where deceased lived. o. STATE Maryland		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	C. LENGTH OF STAY IN 16	c. CITY OR TOWN (If outside corporate lin	nits, write RURAL and give	neorest town)
Sykesville	/Lisse/	X Sykesville		
d. NAME OF HOSPITAL (If not in hospitol, give street OR INSTITUTION Springfield State Hosp		/d. STREET ADDRESS Mineral Hill Road	Route 1	e. IS RESIDENCE ON A FARM? YES NO TO

-	UCLI I UILI							
	b. CITY OR TOWN (If RURAL and give neg	outside corporate limits, write	c, LENGTH OF STAY IN 16	c. CITY OR TOWN (If o	outside corporate	limits, write RL	JRAL and give ne	orest town)
	Sykesy		/lake/	X Sykesvi	lle			
	d. NAME OF HOSPITA	L (If not in hospital, give street	oddressy / / /	d. STREET ADDRESS				e. IS RESIDENCE
5	OR INSTITUTION Springf:	ield State Hosp	ital	Mineral H	ill Road	Rout	e l	YES NO
3.	NAME OF	First	Middle	Lost	4. DATE	Mont	h D	ay Year
L	(Type or print)	JOSEPH	SAMUEL	DUNN	OF DEATH		ctober	31 159
5.	. SEX	6. COLOR OR RACE 7. MARE	HED NEVER MARRIED	B. DATE OF BIRTH	9. 4	GE (In years		R IF UNDER 24 HRS.
	Male	White widowi	DIVORCED	9-7-75		84 yrs.	Months Days	Hours Min.
10	o. USUAL OCCUPATION	N (Give kind of work done 10b.	KIND OF BUSINESS OR INDU	STRY 11. BIRTHPLACE (Stote	or foreign countr	y)	12. CITIZEN	OF WHAT COUNTRY
		1 1 1	hirt Mrife.	Unkhonin	/ Md.		U.	S. A.
13	B. FATHER'S NAME	T.		14. MOTHER'S MAIDEN N	VAME			
4	Samuel	/ Dunn		Unknown	Cath	erine (arlisle	1
	. WAS DECEASED EVER	IN U. S. ARMED FORCES? 16.	SOCIAL SECURITY NO. 17.	INFORMANT	000 011	Addr		
- [res. no. or unknown) (11	yes, give wor or dates of service)	R	ecords of Spr	ingfield	State	Hospita	il .
	18. CAUSE OF DEAT	H [Enter only one couse per li	ne for (a), (b), and (c).]				INI	ERVAL BETWEEN
	PART I. DEAT	H WAS CAUSED BY: IMMEDIATE CAUSE (0)	Cerebral Vasc	nlam Accident			ON	SEI AND DEATH
Т	331X	DUE TO	,					
	Conditions, if on	y, which) (b)	Generalized A	rterioscleros	is			
	gove rise to im	mediate (
	lying couse lost.	(c)						
Z	PART II. OTHE	R SIGNIFICANT CONDITIONS	CONTRIBUTING TO DEATH BUT	NOT RELATED TO THE TERMI	INAL DISEASE CO	NDITION GIV	EN IN PART 1(0)	19. WAS AUTOPSY PERFORMED?
CEPTIFICATION		Hypostatic	Pneumonia an	d CBS ass. W	irth seni	le bra	in dise	SE NO
HE	20a. ACCIDENT WAS	UNDERLYING 206. DES	CRIBE HOW INJURY OCCURRE					
100	(IF EITHER, NOTIFY A	MEDICAL EXAMINER)						
1	20c. TIME OF INJURY	Month, Doy, Year 20d. II	NJURY OCCURRED 20e. PL	ACE OF INJURY (Home, form	, 20f. (City or I	own)	(County) (Stote)
MEDICAL	Hour o.m.	19 While of wor	Not while	ctory, street, office bldg., etc	-)			
		it I attended the deceas	ed from 10-14-	58. 19 to 1	0- 30	19 59	that I last s	nw the decease
	alive on 30	0.0		accurred at 6,15				
			2,2, and mar dean		ADDRESS (Street,			DATE SIGNED
	ACTUAL	Muson Vis	ankora.	pringfi	eld Stat	te Hosp	ital	
	SIGNATURE	14-1200	X	M.D				
	PHYSICIAN'S NAME (Type)	Myron Nizanko	wski	Sykesv	ille, M	aryland	~======================================	
27	BURIAL, CREMATION	, 22b. DATE THEREOF	22c. NAME OF CEMETERY C	R CREMATORY	22d. LOCATION	(City, town, o	r county)	(Stote)
	REMOVAL (Specify) Burial	11/3/59	Druid Ride	re Cem	P	ikesvil	le, Md.	
23	. FUNERAL DIRECTOR'S	SIGNATURE	ADDRESS 2 LL	240. REC'	D BY REGISTRAR		TRAR'S SIGNATU	JRE
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-BALTIMORE, 18 11230

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CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Carroll			MARYLAND	Maryland		b. COUNTY	omery		/
b. CITY OR TOWN (RURAL and give no Sykesvil	If outside corporate limi earest town) 10	ts, write	6 mos. 24		thevy C		URAL ond gi		wn)
d. NAME OF HOSPI OR INSTITUTION	TAL (If not in hospital, g		ldress)	d. STREET ADDRESS				ON	RESIDENCE A FARM?
3. NAME OF DECEASED (Type or print)	Rose		Middle	Last	4. DATE OF DEATH	Mon		Day	Year
5. SEX	6. COLOR OR RACE		D NEVER MARRIED		3000	9. AGE (In years last birthday)	IF UNDER	1 YEAR IF UN Days Hou	
3. FATHER'S NAME	acner, Keti	widowed to be to b	_	February 1, bustry 11. BIRTHPLACE (SIGN OOLS Maryla 14. MOTHER'S MAIDER	ind	88 yrs.		S.A.	T COUNTRY
15. WAS DECEASED EVE	R IN U. S. ARMED FOR (If yes, give war or dates of s	CES? 16. SC	DCIAL SECURITY NO.	Mary INFORMANTSpring Hospital Rec	field S	Erdman State Hoss Sykesvill		rvland	
PART I. DEA 420.0 Canditians, if a gove rise to i couse (o), stoting lying couse lost.	DUE TO	Arte	chopneumonis riosclerotic	heart disea	se			Days	
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ACTUAL SIGNATURE	ober 14,	12 <u>5</u>		19.59, to th accurred at 11:5 M.D. Springf Sykesvi	ADDRESS (S	the causes an street, city or town, er 15, 19 tate Hosp	d an the state)	date stat	
220. BURIAL, CREMATIC REMOVAL (Specify)		959°	22c. NAME OF CEMETERY Druid Rid	ge Cemetery	В	altimore	, M	d.	itote)
23. FUNERAL DIRECTOR		2901	ADDRESS Wa		CT 1 9 '5		STRAR'S SIG		

ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 haurs after death. Page 4 be filed will funeral d by the haspital or attending physician.

*CTOR: After this certificate has been signed by the attending physician and completely filled in a detached for use as the burial-transit permit. Then please remove carban papers. Pages 1 an ar ta burial, cremation, ar remaval, and in any event within 72 hours after death. TO FUNERAL TER TO HOSPITAL VS A15 (4) 15M 9/58

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MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11231

Rea Dist No PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a COUNTY b COUNTY Carroll MARYLAND Marvland Carroll h CITY OP TOWN III autide corporate limits, write RURAL E LENGTH OF STAY IN 16 c. CITY OR TOWN (If gutside corporate limits, write RURAL and give negrest lawn) and nive negreet towns Tanevtown 25 vears Tanevtown d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) A STREET ADDRESS . IS RESIDENCE ON A FARM? 11 Fairview Ave. YES NO TH NAME OF DATE First Middle Lost Year DECEASED DEATH Lauise (Type or print) Marv Essig October 19 59 9. AGE (In years 6. COLOR OR RACE 7. MARRIED T NEVER MARRIED T 8. DATE OF BIRTH IFUNDER LYEAR IF UNDER 24 HRS. lost hirthday) Months Hours WIDOWED [DIVORCED Female White 10a. USUAL OCCUPATION (Give kind of work done) 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) 12 CITIZEN OF WHAT COUNTRY? during most of working life, even if refired) U.S.A. Beautician Own shop Washington. D.C. 13 FATHER'S NAME 14 MOTHER'S MAIDEN NAME Minnie E. Stratton Edgar Essig 15. WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT If yes, give war or dates of service) J. Darrell Nelson, Taneytown, Md. 18. CALISE OF DEATH | Enter only one cause per line for (a), (b), and (c),] INTERVAL BETWEEN ONSET AND DEATH PART I. DEATH WAS CAUSED BY: Occlusion IMMEDIATE CAUSE (a) DUE TO Canditions, if any, which gove rise to immediate cause DUE TO (o), stating the underlying couse lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(9) 19. WAS AUTOPSY PERFORMED? NO CERTIFI 20a. EXTERNAL CAUSE WAS 20b. DESCRIBE HOW INJURY OCCURRED, (Enter nature of injury in Port I or Port II of item 18.) PRIMARY OF CONTRIBUTING CAUSE OF DEATH. 20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, 20f. (City or town) (County) (State) factory, street, office bldg., etc.) Hour o. m. While Nat while at work at work p. m. 21. I certify that I tank charge of the remains described above, held on Autopsy Inspection D and in my opinion death resulted fram: Natural causes Accident , Suicide . Hamicide . Undetermined manner DATE SIGNED ACTUAL CHIEF MEDICAL EXAMINER SIGNATURE ASSISTANT MEDICAL EXAMINER EXAMINER'S NAME (Type) DEPUTY MEDICAL EXAMINER TO 22g. BURIAL CREMATION 22b. DATE THEREOF 22c. NAME OF CEMETERY OR CREMATORY 22d. LOCATION (City, town, or county) (State) REMOVAL (Specify) 10/8/ Burial Reformed Cemetery Taneytown. Marvland 240. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE 23. FUNERAL DIRECTOR'S SIGNATURE 8 '59 arily & Traves

DATE

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FOR STATE

MARYLAND STATE TREATMENT OF HEALTH - BARTHORS, 18
ALEDICAL EXAMINER'S CERTIFICATE OF DEATER.

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CERTIFICATE OF DEATH 11254 directo PLACE OF DEATH 2. USBAL RESIDENCE (Where deceased lived. If institution, Residence before asmission) filed a. COUNTY b. COUNT MARYLAND b. CITY OR TOWN (If autside copporate limits, write c. LENGTH OF STAY IN 16 DR TOWN (If autside corporate limits, write RURAL and give nearest town) PURAL and give nearest town P MAME OF HOSPITAL (If not in Marpital give street address) d. STREET, ADDERESS OR INSTITUTION .5 4. DATE OF DEATH NAME OF Month filled (Type ar print) MARRIED NEVER MARRIED 5. SEX 6. COLOR OR RACE B. DATE OF BIRTH AGE (In years last birthday) WIDOWED DIVORCED [comple yrs. 10a. USYALIOCCUPATION (Give kind of work dane 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or fareign country) dying most of working life, every firetired) dod puo agerstown. Maryland carbon ofter 13. FATHER'S NAME MOTHER'S MAIDEN NAME physician 15. WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL SECURITY NO. INFORMANT Address attending 1B. CAUSE OF DEATH [Enter only one cause per linge for (a), (b), and (c).] ۵ PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) **DUE TO** þ Candilians, if any, which signed gave rise to immediate DUE TO cause (a), stating the underlying cause last burial-tronsit physician ART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE/TERMINA), DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPSY ending 20g. ACCUPENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) certificate MEDICAL 20c. TIME OF INJURY Month. 20e. PLACE OF INJURY (Hame, farm, 20f. (City or town) Day, Year 20d. INJURY OCCURRED factory, street, affice bldg., etc.) a. m. While Nat while at wark ot wark 19_2_1that I last saw the deceased 21. I certify, that I attended the deceased fram toched and that death occurred at 3 alive an CTOR: _M, fram the causes and an the date stated above. ADDRESS (Street, city or lays, state) det ACTUAL SIGNATURE FUNERAL PHYSICIAN'S NAME (Type) 22a. BURIAL, CREMATION, 22b. DATE THEREOF 22c. NAME OF CEMETERY OR CREMATORY 22d. LOCATION (City, tawn, or county) poge REMOVAL (Specify) 0565 E 17/LL CEMETER URIAL 0 23. FUNERAL DIRECTOR'S SIGNATURE 24b. REGISTRAR'S SIGNATURE 24g. REC'D BY REGISTRAR DATE NOV 1 0 '59 Orthur S. Krone VS A15 (4)

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

Rea. Dist. No

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e. IS RESIDENCE

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IF UNDER 1 YEAR IF UNDER 24 HRS

U.S.A.

12. CITIZEN OF WHAT COUNTRY?

Hours

INTERVAL BETWEEN ONSET AND BEATH

> PERFORMED? YES NOT

> > (State)

DATE SIGNED

(State)

Days

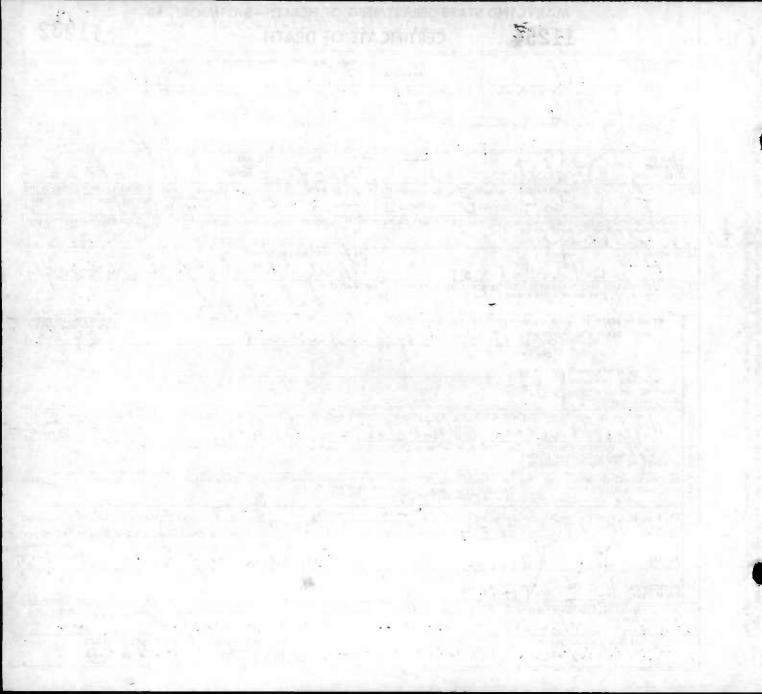
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ON A FARM? YES NO

Year

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death. within 24 hours deoth 15M 9/5B



MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

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Pages 1 and 2

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 Item 9 FilmG251 11-5159 et CERTIFICATE OF DEATH

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1. PLACE OF DEATH a. COUNTY	arroll	MARYLAND	2. USUAL RESIDENCE a. STATE	(Where deceased ryland	lived. If institution b. COUNTY		fore admission)		
RURAL and give n	If outside corporate limits, we earest town)			(If outside corpore		URAL ond give r	nearest town)		
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OR INSTITUTION	TAL (If not in hospitol, give seld State Hos		d. STREET ADDRE	wyanoke	Ave.		e. IS RESIDENCE ON A FARM YES NO		
3. NAME OF DECEASED (Type or print)	first Ma rv	Middle Agnes	FOLEY	4. DATE OF DEATH	Octob		Day Year 28. 1959		
S. SEX		MARRIED NEVER MARRIED K	1	19	P. AGE (In years	7	AR IF UNDER 24 H		
Female	H 60 A A	DOWED DIVORCED	November 2		61 60/ yrs.	Months Days	Hours Mi		
during most of wor	ON (Give kind of work done king life, even if retired) e operator	10b. KIND OF BUSINESS OR INI	DUSTRY 11. BIRTHPLACE (untry)		OF WHAT COUNT		
3. FATHER'S NAME	- 0,000		14. MOTHER'S MAIL						
John P.	Foley		Wilhel	mina Deet	tzen				
1S. WAS DECEASED EVI (Yes, no, or unknown)	R IN U. S. ARMED FORCES? (If yes, give wor or dates of service)		Springfield	Hospital	Records				
	ATH WAS CAUSED BY: IMMEDIATE CAUSE (o) DUE TO Iny, which m mediate DUE TO	Septicemia Infected gang	grenous decu	bitus ulc	eers	1	ITERVAL BETWEE NSET AND DEAT . week		
Iying cause last. (c)									
20c. TIME OF INJURY Month, Doy, Year 20d. INJURY OCCURRED to factory, street, office bldg., etc.) 20f. (City or town) (County) (Sunty)									
21. I certify the	21. I certify that I attended the deceased fram February 8, 1956, to October 28, 1959, that I last saw the deceased alive an October 28, 1959, and that death accurred at 10:00 M, from the causes and an the date stated above ADDRESS (Street, city or town, state) ACTUAL SIGNATURE O GUISLIN Colored M.D. Springfield State Hospital 10/28/59 PHYSICIAN'S								
220. BURIAL, CREMATIC REMOVAL (Specify Burial)		122c. NAME OF CEMETERY New (athed)	1 (1011.	more, Mo	or county) anyland	(State)		
23. FUNERAL DIRECTOR	'S SIGNATURE	Baltimore St.	Balto. DATI	REC'D BY REGISTE		STRAR'S SIGNAT	-		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 haurs after death. Page 4 TO HOSPITAL OR ATTENDING PHISICIAN.

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Item 20 Film 2MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18 11235 MEDICAL EXAMINER'S CERTIFICATE OF DEATH please execremation Rea, Dist. No. PLACE OF DEATH 2. USUAL RESIDENCE (Where deseased lived. If Institution: Residence before admission) a. COUNTY b. COUNTY MARYLAND b. CITY OR TOWN (If outside corporate limits, write RUBAL c. LENGTH OF STAY IN 16 c. CITY OR TOWN (If autside carporate limits, write RURAL and give gearest town) e. IS RESIDENCE d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street oddress) d. STREET ADDRESS ON A FARM? YES Y NO NAME OF Middle 4. DATE Month funerol DECEASED OF DEATH 195 (Type or print) 9. AGE (In years 5. SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED 8. PATE OF BIRTH IF UNDER TYEAR IF UNDER 24 HRS. Days Min. Months Hours WIDOWED | DIVORCED T yrs. 10g, USUAL OCCUPATION (Give kind of work dane 10b, KIND OF BUSINESS OR INDUSTRY 11, BIRTHPLACE (State or fareign country) 12. CITIZEN OF WHAT COUNTRY? during most of working life, even if retired) C Herris Harine ond V3. FATHER'S NAME 14. MOTHER'S MAIDEN NAME moy poges Pages oge 5 r Poge 17. INFORMANT 15. WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL SECURITY NO. within Give 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c). INTERVAL BETWEEN ONSET AND DEATH PART I. DEATH WAS CAUSED BY: FFRACTURES farm m IMMEDIATE CAUSE (a) in Item DUE TO with Conditions, if any, which ! pencil along gave rise to immediate cause DUE TO (a), stating the underlying cause last. Office PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPSY OS PERFORMED? NO T 20a. EXTERNAL CAUSE WAS PRIMARY OF CONTRIBUTING CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Port 1 or Port 11 of item 18.) be Exomi Automobile Accident should word Month, Day, Year 20d. INJURY OCCURRED | 20e. PLACE OF INJURY (Hame, form, | 20f. (City or tawn) 20c. TIME OF INJURY (County) (State) ficate, writing the wo the Chief Medical E RECTOR: Page 3 sho factory, street, office bldg., etc.) Hour & m Not while Md. Hampstead Carroll 1959 Hanover at work ot work 21. I certify that I took charge of the remains described above, held an Autopsy Inspection Inquiry X and find that death resulted from: Natural causes , Accident Suicide Homicide Undetermined cause DATE SIGNED ACTUAL CHIEF MEDICAL EXAMINER SIGNATURE ASSISTANT MEDICAL EXAMINER orded EXAMINER'S FUNER! DEPUTY MEDICAL EXAMINER NAME (Type) 220. BURIAN CREMATION. 22b. DATE THEREOF 22c. NAME OF CEMETERY OR CREMATORY 22d. LOCATION (City, town, or county) MEMIDVAL (Specify) 0 23, PUNERAL DIRECTOR'S SIGNATURE **ADDRESS** 240. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE VS. A15ME(5) DATE 5M 9/55

LENCAL EXAMINER'S CERTIFICATE OF DEATH

VS A15 (4) 15M 10/57

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 I tem 1 FilmG250 10-28-59 et CERTIFICATE OF DEATH

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	d. NAME OF HOSPITA	AL (If not in nospital, g	ive street	oddress)		d. STREET A						RESIDE	
	Gosnell	Nursing 1	lome			1 Par	rk Ave	•			YE	5 🔲 🙌	0 🗆
	3. NAME OF DECEASED (Type or print)	Fir MY	RTLE	Middle F	F	RANKLIN	al ,	4. DATE OF DEATH	Man	oct.	Doy 17,	Year	59
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	during most of work	ng lite, even if retired	done 10b.	KIND OF BUSINESS OR	INDUS		ACE (Stote o	r foreign c	ountry)	12. CIT	IZEN OF W	HAT CO	UNTRY?
	3. FATHER'S NAME	one	-	~		Md							
						14. MOTHER'S							
	John Sefton	-					orah F	outz					
1	5. WAS DECEASED EVER	IN U. S. ARMED FOR f yes, give wor or doles of s		SOCIAL SECURITY NO.		VFORMANT			Add			Md.	
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	PART II. OTH 200. ACCIDENT WAS OR CONTRIBUTING UJ (IF EITHER, NOTIFY)	ER SIGNIFICANT CON	DITIONS C	CONTRIBUTING TO DEATH	H BUT	NOT RELATED TO	THE TERMIN	IAL DISEAS	E CONDITION GIV	EN IN PART	PE	RFORME	D?
	OR CONTRIBUTING	☐ CAUSE OF DEATH I	20b. DESC	CRIBE HOW INJURY OCC	URREC). (Enter nature a	f injury in Po	ert 1 or Port	I II of item 1B.)				
	20c. TIME OF INJURY Hour o. m. p. m.	Month, Day, Yes	While	NJURY OCCURRED Not while of work	De. PLA foc	ACE OF INJURY (I lory, street, office	Home, form, bldg., etc.)	20f. (City	or town)	(C	ounty)	5	(State)
4	21. I certify the	at Jattended the	decease	ed fram.	S	2_, 19	, to 12	au	1957	.that 1 1	ast saw t	he de	ceased
	alive an	act	_, 19	, and that d	eath	occurred at	1:38K	M, fran	n the causes a	nd an th	e date s	tated (above
	ACTUAL &	6	9.	AU.			Aho	DDRESS (SI	reet, city or town	stote)	17/		SIGNED
	SIGNATURE	MAME S		HOOC		w.D	7414	vin	2/		110	cy.	3/
	PHYSICIAN'S NAME (Type)	OWAY	7	E. HA	1	6	3	YKE	SVIL	Le.	MI),	
1	20. BURIAL, CREMATION REMOVAL (Specify)	I, 22b. DATE THEREO	F	22c. NAME OF CEMETE	RY OF	CREMATORY	:	22d. LOCAT	TION (City, town, o	or county)		State)	
1	Burial	10/20/5	9	Lorraine	Pa	rk Cem.		Wood	lawn, Md	•			
12	3. FUNERAL DIRECTOR'S	SIGNATURE	. 0/	ADDRESS	5	177	24a. REC'D	BY REGIST	RAR 24b. REGIS	STRAR'S SIG	NATURE		
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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

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1. PLACE OF DEATH a. COUNTY	21200		MARYLAND	2. USUAL RESIDENCE (W		lived. If institution b. COUNTY	on: Residence l	before admi	ission)
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RURAL and give nearest town)						7110	1 - A		
d. NAME OF HOSPIT	TAL (If nat in haspital, g	give street		Baltime d. STREET ADDRESS	ore		200		ESIDENCE
OR INSTITUTION Henry to	n State Ho	spit	al	904 N.	Gilmon	r Street			A FARM?
3. NAME OF DECEASED	Fi	rst	Middle	Last	4. DATE	Mon		Day	Year
(Type or print) 5. SEX	Eth	_	Lee	Hall	DEATH	Oct	IF UNDER 1 Y	25,	19 59
Female	6. COLOR OR RACE	WIDOW	RIED NEVER MARRIED DIVORCED DIVORCED	B. DATE OF BIRTH June ? 1	91.2	9. AGE (In years last birthdoy) 47 yrs.	Months Do	-	-
10a. USUAL OCCUPATIO	ON (Give kind of work king life, even if retired	done 10b.	KIND OF BUSINESS OR INDL	JSTRY 11. BIRTHPLACE (Stot	e or foreign co	ountry)	12.CITIZEN	OF WHAT	COUNTRY?
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13. FATHER'S NAME				14. MOTHER'S MAIDEN	NAME				771
Unkne	own			Betty	A. Gro	OSS			
1S. WAS DECEASED EVE	R IN U. S. ARMED FOR (If yes, give wgr or dates of s	CES? 16.	SOCIAL SECURITY NO.	INFORMANT		Addr	ess	100	
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Conditions, if d gove rise to i couse (o), stating lying couse last. PART II. OTH	mmediate the under-	o) o	uberculosis	T NOT RELATED TO THE TERM	-	CONDITION GIV	EN IN PART 1	o) 19. WAS	S AUTOPSY FORMED?
	AS HINDERWING FI	20L DEC	CRIRE HOW INTINEY OCCURR	FD /F-1	Park Lan Park	II of them 10)		YES] NO [
U (IF EITHER, NOTIFY	CAUSE OF DEATH MEDICAL EXAMINER)	206. DES	CRIBE HOW INJURY OCCURRI	ED. (Enter noture of injury in	ron I or ron	II of Item 15.)			
Hour o.m.	RY Month, Day, Ye	While of wor	Not while fo	LACE OF INJURY (Home, for actary, street, office bldg., e	tc.)		(Cou		(Stote)
actual SIGNATURE PHYSICIAN'S Dr. NAME (Type) 22a. BURIAL CREMATIC	elgars M Edgars M on, 22b. Date thereco	. 19 . Ma		M.D. Henryton	AM, from the ADDRESS (Street on , Ma	the causes and reet, city or town, aryland	d on the d	ate state 10- rytor	ed abave. ATE SIGNED -25-59
REMOVAL (Specify)	10-29-5		my. au	lum		Ball	5 2	not	niej
23. FUNERAL DIRECTOR	S SIGNATURE	Su	elevand.	Ballo DATE	OCT 28 E		TRAR'S SIGN	ATURE	

VS A15 (4) 15M 10/57 M

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11261 CERTIFICATE OF DEATH

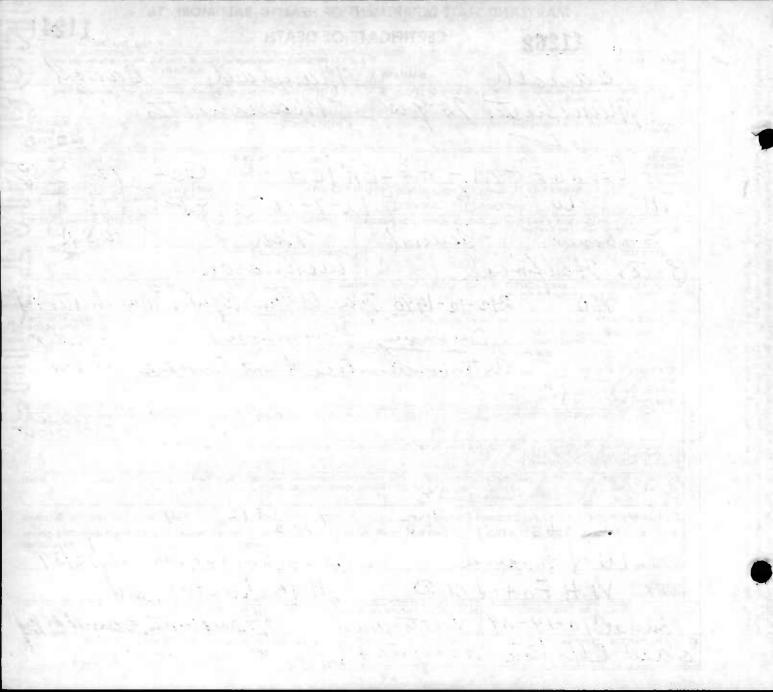
1. PLACE OF DEATH O. COUNTY ANTOLL MARYLAND	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE b. COUNTY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	c. CIDY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X MULLA Systematical
d. NAME OF HOSPITAL (If not in hospital, give street oddress) OR INSTITUTION	d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES \(\) NO
3. NAME OF DECEASED (Type or print) May that JANE H	AMRICK 4. DATE Month Day Year DEATH OCTOBEY 1959
5. SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED WIDOWED DIVORCED	B. DATE OF BIRTH July 3, 1894 9. AGE (In years FUNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. Months Days Hours Min. Mi
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) However the state of working life, even if retired)	W. Va. 4.S.A.
13. FATHER'S NAME (INKNOWN)	14. MOTHER'S MAIDEN NAME UNKNOWN
15. WAS DECEASED EVER IN U. S. ARMED FORCES? If on, no or unknown) (If yes, give wor or dotes of service) There	dward Hamich Alghisville, Med.
18. CAUSE OF DEATH [Enter only one couse per line for (o), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) DUE TO	lure, Carelle sura of Interval Between ONSET AND DEATH
Conditions, if ony, which gove rise to immediate couse (a), stating the underlying couse last. (b) Plun Creas (b) Plun Creas (c) Userma, plus	rel effusion. 10cx 59
PART 11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO BEATH BUT	T NOT RELATED 40 THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) 19. WAS AUTOPSY PERFORMED? YES NO
OR CONTRIBUTING I CAUSE OF DEATH	ED. (Enter nature of injury in Part 1 or Part 11 of item 18.)
20c. TIME OF INJURY Month, Doy, Year Hour o. m. 19 While Not while of work 10 to work 12 to 19	LACE OF INJURY (Home, form, 20f. (City or town) (County) (Stote) ctory, street, office bldg., etc.)
ACTUAL FLORING 1 & WALLS	n accurred at 150 5 AM, fram the causes and an the date stated abave. ADDRESS (Street, city or town, state) DATE SIGNED
PHYSICIAN'S HOWAYD E, HAL	N SYKESVILLE, M.D.
220. BURIAL, CREMATION, 22b. DATE THEREOF 22c. NAME OF CEMETERY OF PREMOVAL (Specify) 10-4-59 (Maigne	OR CREMATORY 22d. LOCATION (City, town, or county) (Stote)
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS ADDRESS ADDRESS ADDRESS	240. REC'D BY REGISTRAR 246. REGISTRAR'S SIGNATURE CITILINA & HALLA

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requires that the deoth certificate be executed within 24 hours after deoth. Page 4 ATTENDING PHYSICIAN: The low TO HOSPITAL OR VS A15 (4) 1SM 9/SB 11241

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

	PLACE OF DEATH O. COUNTY Allicell MARYLAND	2. USUAL RESIDENCE (Where deceosed lived. If institution: Residence of STATE b. COUNTY b. COUNTY	before admission)
	b. CITY OR TOWN (If autside corporate limits, write RURAL and give nearest town)	c. CITY OR TOWN/Iff outside corporate limits, write RURAL and g	
	d. NAME OF HÖSPITAL (If not in hospital, give street address) OR INSTITUTION	d. STREET ADDRESS	e. IS RESIDENCE ON A FARM? YES NO
	NAME OF DECEASED (Type or print) GEORGE—M— HEL	FRICH 4. DATE OF DEATH	Day Year 19-59
5. :	SEX 6. COLOR OF RACE 7. MARRIED NEVER MARRIED	Si Sint Sint Sint Sint Sint Sint Sint Si	Days Hours Min.
10a	D. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	STRY 11. BIRTHPLACE (State or foreign country) 12. CITIZ	US A
13.	Reter Helfrich	14. MOTHER'S MAIDEN NAME WILLIAGEON	
1S. (Ye	WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL SECURITY NO. 18. no. or unknown) 212-11-1490	Husld Transletorten Man	abester My
	IB: CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (c) DUE TO DUE TO	Thumbous to 1000	INTERVAL BETWEEN ONSET AND DEATH - 10 MIN
7	Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) Culturable (b) Culturable (c)	rolle I flant I stark	J's.
CATION	PART II. OTHER SIGNIFICANT CONDITIONS <u>CONTRIBUTING TO DEATH</u> BUT	T NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART	PERFORMED? YES NO
CERTIF	200. ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURRE OF CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	ED. (Enter nature of injury in Part I or Port II of item 18.)	
MEDICAL		ACE OF INJURY (Home, farm, 20f. (City or town) (Cotory, street, office bldg., etc.)	ounty) (State
	21. I certify that I attended the deceased fram and alive an Got 3, 1859, and that death ACTUAL SIGNATURE WITH TOWNSICIAN'S NAME (Type) W. H. FOAT JM. P	n accurred at OAM, from the causes and an the ADDRESS (Street, city or town, state) MANCHES TET MILL MILL	
220	BURIAL, CREMATION. 22b. DATE THEREOF 22c. NAME OF CEMETERY CREMITORY 16-14-59 Zuttless	OR CREMATORY 22d. LOCATION (City town, or country)	woll ex In
8	FUNERAL DIRECTOR'S SIGNATURE STORE PADDRESS STEELE	240. REC'D BY REGISTRAR 24b. REGISTRAR'S SIG	



VS A15 (4) 15M 9/55

ARYLAND	STATE	DEPARTMENT	OF HEALTH-BALTIMORE,	18
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11240 CERTIFICATE OF DEATH

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1. PLACE OF DEATH a. COUNTY AVOIL MARYLAND	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE b. COUNTY AMALIA
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	c. CITY OR TOWN (If ausside corporate limits, write RURAL and give nearest town)
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION OR INSTITUTION	d. STREET ADDRESS 178 / Anlew At YES NO
3. NAME OF First Middle (Type or print) BLDNCHE H	IPSLEV 4. DATE Month Day Year OF DEATH OCT. 26 1959
5. SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED WIDOWED DIVORCED	8. DATE OF BIRTH 9. AGE (In years last birthday) 9. AGE (In years lif UNDER 1 YEAR IF UNDER 24 MRS. Months Days Haurs Min.
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	11. BIRTHPLACE (Stote or foreign country) 12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME Martha Hood
15. WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. IN (Yes, no. of unknown) (If yes, give wor or dates of service)	FORMANT Places 178 2 these I mi
18. CAUSE OF DEATH [Enter only one couse per line far (a), (b), and (c).] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) DUE TO Candillons, if any, which gave rise to immediate coess (a), stoting the under-lying couse last. Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT	INTERVAL BETWEEN ONSET AND DEATH SEVERAL SEVE
OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	D. (Enter nature of injury in Port I ar Part II af item 18.)
20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED Haur a. m. 19 While Nat while at work at wark	ACE OF INJURY (Home, farm, 20f. (City or tawn) (County) (State)
21. I certify that I attended the deceased fram deceased f	accurred at 5 MAM, from the causes and an the date stated abave. ADDRESS (Street, city or toys), state) DATE SIGNED LOCAL LANGUAGE ADDRESS (Street, city or toys), state)
220. BURIAL, CREMATION, 22b. DATE THEREOF . 22c. NAME OF CEMETERY OF REMOVAL (Specify) 23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS	R-CREMATORY— 22d. LOCATION (City, town, or county) (Stote) 24a, REC'B'BY REGISTRAR 24b, REGISTRAR'S SIGNATURE
4. E. Myle, py Westminter,	Med - DATE NOV 2 '59 Carthur S. Forma

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 haurs after death. Page 4 may be retained by the haspital or attending physician. TO FUNERAL PACECTOR: After this certificate has been signed by the attending physician and campletely filled in the funeral director, page 3 shave a detached far use as the burial-transit permit. Then please remave carbon papers. Pages 1 and should be Titled with the registrar prior to burial, cremation, ar remaval, and in any event within 72 haurs after death.

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MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18 11909

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1. PLACI	e of DEATH DUNTY Carre	011		N	MARYLAND	2. USUAL RESIDENCE O. STATE	E (Where decease	d lived. If instituti b. COUNTY		to.		ion)
b. CIT	Y OR TOWN (If	outside carporate lin	nits, write	c. LENGTH OF S	STAY IN 16	c. CITY OR TOW	N (If outside corpo	orate limits, write F	RURAL ond	give ne	prest tawn	1)
	Marco D. 100 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1			hlyrs.1	2days	Balti	lmore	3	VOI	- 4		
OR	INSTITUTION	(If not in hospital,				d. STREET ADDR		View.				FARM?
3. NAMI DECE	E OF ASED or print)		irst	Mi	iddle	Hogan	4. DATE OF DEATH	Octobe		Do	•	Year
S. SEX		6. COLOR OR RACE		NED TO NEVER W	4 DOLED	B. DATE OF BIRTH	DEATH	9. AGE (In years	-	P I YEAR	IF UNDE	19 59
	le	White	WIDOW		DRCED	1872		lost birthdoy) 87 yrs.	Months	-	Hours	Min.
duri	IAL OCCUPATION ng most of working	(Give kind of working life, even if retire	done 10b. d)	KIND OF BUSINE	SS OR INDU	Unkne		country)	12.CI		know	
	ER'S NAME			10010		14. MOTHER'S MA			1	01	IKIIOW	41
Ur	known					Unkno	own					
(Yes, no, o	r unknown) (If	IN U. S. ARMED FO yes, give war or dates of		SOCIAL SECURITY		INFORMANT		Add			144	700
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ga cau lyir	nditians, if one verise to imuse (a), stating the ng couse last.	mediate DUE To	D b) D			chopneumoni		E CONDITION GI	VEN IN PA	I	9. WAS /	AUTOPS)
(IF E	ITHER, NOTIFY M	UNDERLYING CAUSE OF DEATH				ED. (Enter noture of inju						
WEDICAL 20c.	TIME OF INJURY Havr a. m. p. m.	Month, Doy, Yo	While	NJURY OCCURRED Not while of wark	fo	LACE OF INJURY (Homo octory, street, office bld	g., etc.)	y ar town)		(County)		(Stote
ACTI SIGN PHY: NAM	Ve an Octo	Agustin de	cle cle	O Com			ADDRESS (S ADDRESS (S ADDRESS (S ADDRESS (S ADDRESS (S ADDRESS (S ADDRESS (S ADDRESS (S ADDRESS (S ADDRESS (S	the causes are street, city or town, sate Hosp	nd an th stote) ital	ne date	stated	
13	WILLEY	10-6-	^{of} 59	22c. NAME OF	CEMETERY C	thedeal	13	NON (City John	ou	2/	(State	e)/
3. FUNE	RAL-DIRECTOR'S	SIGNATURE STA	right	ADDRESS	hen	alle Mill	REC'D BY REGIS		STRAR'S S			

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TO FUNERAL PREC the registrar

VS A15 (4) 1SM 9/SB

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

		1126	à	C	ERTIFICA	ATE OF DEATH	1		Reg. Dist	t. No.	
R P	LACE OF DEATH	rroll	*		MARYLAND	2. USUAL RESIDENCE (WH		lived. If institution b. COUNTY	n: Residence		dmissian)
E	CITY OR TOWN (IF RURAL and give nec Sykesvi)	autside carporate lim gest tawn)	ts, write		mos .7da	c. CITY OR TOWN (IF o			URAL and gi	ive nearest	tawn)
(or institution Springfi	L (If not in hospitol, queld State	Hosp:	address) ital	5-27	d. STREET ADDRESS				0	RESIDENCE ON A FARM?
	NAME OF DECEASED Type ar print)	Lydi	-	sadore	Middle Love	Keilholtz	4. DATE OF DEATH	Octob		Doy 26,	Year 19 59
s. s	Female	6. COLOR OR RACE White	7. MARE	-	R MARRIED	B. DATE OF BIRTH July 20, 18		9. AGE (In years last birthday) 85 yrs.			JNDER 24 HR
0a.	USUAL OCCUPATIO during most of worki Housewif	ng life, even if retired	dane 10b.	KIND OF BUS	INESS OR INDU	ISTRY 11. BIRTHPLACE (State Maryland	ar foreign cou	untry)		S.A	IAT COUNTRY
3.	PATHER'S NAME David Lo	we			Ellis-	14. MOTHER'S MAIDEN N					
(Yes,		IN U. S. ARMED FOR f yes, give wor or dates of s		SOCIAL SECUI		NFORMANT Springfield H	ospita.	Adde			
-	Canditians, if an gave rise to im cause (a), stating to lying cause last.	he <u>under-</u>	Ge	enerali		er io sclerosis				Year	rs.
CERTIFICATION	20g. ACCIDENT WAS	right tibi S UNDERLYING CAUSE OF DEATH	a and	d right	fibula	with psychot Pulmonary D. (Enter nature of injury in label)	tubercu	losis.	EN IN PART	1(a) 19. V P YE:	VAS AUTOPS' ERFORMED? SE NO
MEDICAL	20c, TIME OF INJURY Haur a.m. p. m.	Manth, Day, Ye	While	NJURY OCCUR Nat while k at wark	e fo	ACE OF INJURY (Hame, farm letary, street, affice bldg., etc		ar tawn)	(Co	aunty)	(State
	21. I certify the	ober 26,	deceas , 19_	ed from N 59, an	lay 19, d that death		M, from the ADDRESS (Street	26, 1959, he causes an eet, city or town, tate Hos	d an the	t saw th	ne decease oted above DATE SIGNE
	ACTUAL SIGNATURE PHYSICIAN'S	justin a									

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	11.
PLACE OF DEATH o. COUNTY	35
b. CITY OR TOWN (IF RURAL ond give ned	outside corporot
Sykesville d. NAME OF HOSPITA OR INSTITUTION Springfield	AL (If not in hosp
NAME OF DECEASED	Earl K
SEX	6. COLOR OR R
Male la. USUAL OCCUPATION during most of worki	White
Farmer an	

1265	CERTIFICATE OF DEAT

Reg. Dist. No. 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. COUNTY MARYLAND Maryland Montgomery e limits, write c. LENGTH OF STAY IN 16 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 11mths.5days Monrovia. Maryland ital, give street address) d. STREET ADDRESS e. IS RESIDENCE ON A FARM? Hospital YES NO 4. DATE First Middle Month Year DEATH indlev October Linthicum 19 50 ACE 7. MARRIED T NEVER MARRIED B. DATE OF BIRTH 9. AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS lost birthdoy) Months Doys WIDOWED | DIVORCED | November 22,1893 work done 10b, KIND OF BUSINESS OR INDUSTRY 11, BIRTHPLACE (State or foreign country) 12. CITIZEN OF WHAT COUNTRY? Farmer &Music Tescher Maryland American 14. MOTHER'S MAIDEN NAME Mary Prudum Miel Linthicum 15. WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL SECURITY NO INFORMANT Address unknown Linthicum. Monrovia, Md. 18. CAUSE OF DEATH [Enter only one couse per line for (o), (b), and (c).] INTERVAL BETWEEN ONSET AND DEATH PART I. DEATH WAS CAUSED BY Myocardial Infarction IMMEDIATE CAUSE (o) DUE TO days Cerebro- Vascular accident Conditions, if ony, which gove rise to immediate DUE TO couse (o), stoting the underlying couse lost PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(6) 19. WAS AUTOPSY PERFORMED? YES NO TO 200. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b, DESCRIBE HOW INJURY OCCURRED, (Enter nature of injury in Port I or Port II of item 18.) 20c. TIME OF INJURY 20e. PLACE OF INJURY (Home, farm, 20f. (City or town) Day, Year 20d. INJURY OCCURRED (County) (Stote) foctory, street, office bldg., etc.) o. m. Not while of work of work 21. I certify that I ottended the deceased from 195 (that I lost sow the deceased and that death occurred at 1132AM, from the causes and on the dote stoted obove. alive on ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) 220. BURIAL, CREMATION. 22b. DATE THEREOF 22c. NAME OF CEMETERY OR CREMATORY 22d. LOCATION (City, town, or county) (Stote) REMOVAL (Specify) Montgomery 24g. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE **ADDRESS** Damascus, OCT 2 8 '59

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Reg. Dist. No.

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А.	PLACE OF DEATH a. COUNTY	Carroll		MARYLA		a. STATE	e (Where decease rvland	ed lived. If instituti b. COUNTY	on: Residence	e befare 11	admissi	on)
	RURAL and give n	If autside carporate limits,		c. LENGTH OF STAY IN	1b X			windso	URAL and gi	ve near	est tawn)
ı		TAL (If not in hospital, give		ddress)	1	d. STREET ADDRES	ss arston			e	ON YES	DENCE FARM? NO
3.	NAME OF DECEASED (Type ar print)	First	3 3	Middle BENJAMAN	LO	NG-	4. DATE OF DEATH	Man OC!		23,		9 59
S.	male	6. COLOR OR RACE 7	MARRIE			TE OF BIRTH 0-9-188	8	9. AGE (In years last birthdoy) 71 yrs.	Manths [YEAR I	Hours	R 24 HRS. Min.
	o. USUAL OCCUPATION during most of war	ON (Give kind of work do king life, even if retired)	1000	IND OF BUSINESS OR I		Maryl	and	country)		.S.	WHATC	OUNTRY?
13.	FATHER'S NAME	homas Long	ζ		14	Marth	en name	k				
15. (Ye	WAS DECEASED EVE rs, no. or unknown)	ER IN U. S. ARMED FORCE (If yes, give war or dates of serv	ice)	7-36-4084		MANT s. Bess	ie Lon	Add same				
		mmediate DUE TO	a_	ortic s	ster	mie				ONSE	JED	DEATH
CERTIFICATION	20a. ACCIDENT W.	HER SIGNIFICANT CONDI	in	ONTRIBUTING TO DEATH	rien	- Cu			VEN IN PART	1(a) 19	YES T	AUTOPSY RMED? NO
MEDICAL	20c. TIME OF INJUI Hour a. m. p. m.		20d. IN While at wark	Not while	e. PLACE foctory,	OF INJURY (Hame, street, affice bldg	, farm, 20f. (Ci	ty ar tawn)	(Co	ounty)		(State)
22	21. I certify the alive an CC ACTUAL SIGNATURE PHYSICIAN'S NAME (Type)	J. H. CAR	. 12 5	and that d	eath occ	ils 5	M, fram ADDRESS (nd an the state)		stated	abave.
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23.	FUNERAL DIRECTOR	WALTZ, W	inf:	ield, Md.			REC'D BY REGI		ISTRAR'S SIG		E	

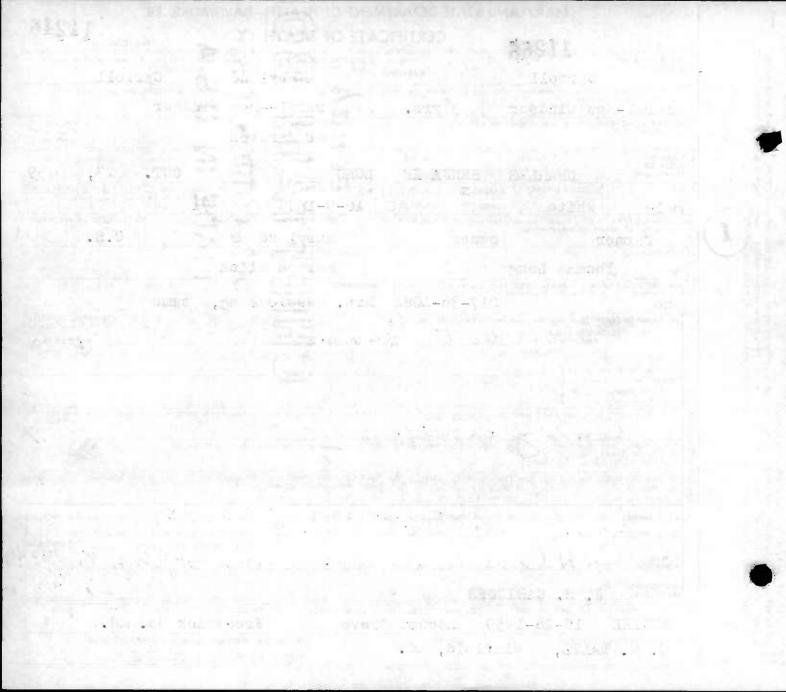
TO HOSPITAL OR may be retained TO FUNERAL page 3 sho VS A1S (4) 1SM 9/58

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ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 haurs after death. Page 4

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 Reg. Dist. No. 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) e. IS RESIDENCE ON A FARM? YES NO Day 19 IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours 12. CITIZEN OF WHAT COUNTRY? INTERVAL BETWEEN ONSET AND DEATH PERFORMED? YES NO D (County) (State) ___that I last saw the deceased , and that death accurred at 2/5 & M, from the causes and an the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 116/00 22d. LOCATION (City, tawn, or county) (State) 24b. REGISTRAR'S SIGNATURE

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	PLACE OF DEATH									
	county	Carroll		MARYLAND	2. USUAL RESIDENCE O. STATE Mar	E (Where decea yland	sed lived, If insti b. COUN		dence before	a admission)
		(If autside carporate limits,	write c. LENGTH O	F STAY IN 16	c. CITY OR TOW	N (If outside cor	porote limits, wri	e RURAL on	d give near	est town)
-	RURAL ond give	Henryton	47	days	Bal	timore		3 V 01	-16-	
	d. NAME OF HOSP	ITAL (If nat in haspital, giv	e street address)		d. STREET ADDR	ESS			6	. IS RESIDENCE ON A FARM?
	OK INSTITUTION	Henryton St	ate Hospi	tal	416	S. Spr	ing Str	eet		YES NOX
	NAME OF DECEASED (Type ar print)	First Hatt	ie Ca	Middle therine	Last Mitche	4. DATE OF DEAT		Month	Day	Yeor 1959
5. 5	SEX	6. COLOR OR RACE	MARRIED NEVER	MARRIEDXX	B. DATE OF BIRTH		9. AGE (In ye		ER 1 YEAR	F UNDER 24 HRS
]	Temale	1		VORCED [April 30	. 1913	lost birthdo		s Days	Hours Min.
	USUAL OCCUPATION of the during most of the NO1 NO1 FATHER'S NAME	ION (Give kind of work do rking life, even if retired) 10	None		STRY 11. BIRTHPLACE	(State or foreign		12.0	U.S.	WHAT COUNTRY
13.		2011								
/25		hn Mitchell	ES? 16. SOCIAL SECUR	TV NO. III	Lda S	tewart		Address		
	s, no, or unknown)	(If yes, give wor or dates of serv				Ma Lab				to., Md.
-	No	NO ATH [Enter only one cous			Hattie C	. Mitch	iell - 4	16 S.		LNE .
CATION	gove rise to couse (o), stoting lying couse lost PART II. OT	the under-	TIONS CONTRIBUTING	TO DEATH BUT	NOT RELATED TO THE	TERMINAL DISEA	ASE CONDITION	GIVEN IN P.		. WAS AUTOPSY PERFORMED? YES NO
CERTIFI	20a. ACCIDENT W OR CONTRIBUTING (IF EITHER, NOTIF	'AS UNDERLYING ☐ 2G ☐ CAUSE OF DEATH Y MEDICAL EXAMINER)	0b. DESCRIBE HOW IN	JURY OCCURRE	O. (Enter noture of inju	ury in Port I or P	ort II of item 1B.			
MEDICAL	20c. TIME OF INJU Hour o. m. p. m.	19	While Nat while at work of work	foo	ACE OF INJURY (Home story, street, affice bld	g., etc.)			(County)	(Stote
	alive on Oc		deceased from $\frac{A}{1959}$, and $\frac{A}{1959}$	d that death	occurred at 5:	OOAM, from	n the causes (Street, city or to	and an t		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 haurs after death. Page 4 may be retained by the haspital ar attending physician. VS A1 the last the state of the state IN THE terminated by the state of the second responsibilities and the second responsibilities and the second responsibilities are selected as the second responsi

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 CERTIFICATE OF DEATH 11247 MARYLAND c. LENGTH OF STAY IN 1b d. STREET ADDRESS

Reg. Dist. No. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. COUNTY b. COUNTY b. CITY OR TOWN (If autside carporate limits, write c. CITY OR TOWN (If autside carporate limits, write RURAL and give nearest town) RURAL and give nearest town) d. NAME OF HOSPITAL (If not in hospital, give street address) e. IS RESIDENCE OR INSTITUTION ON A FARM? YES NO T NAME OF Middle 4. DATE Month Day Year DECEASED OF (Type or print) 195 S. SEX 8. DATE OF BIRTH 9. AGE (In years IF UNDER I YEAR IF UNDER 24 HRS 7. MARRIED T NEVER MARRIED last birthday) Months Days WIDOWED F DIVORCED 10a. USUAL OCCUPATION (Give kind of work done) 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country 12. CITIZEN OF WHAT COUNTRY? during most of working life, even if retired) 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME 15. WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] INTERVAL BETWEEN ONSET AND DEATH PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) DUE TO Canditians, if any, which gave rise to immediate **DUE TO** catse (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(01) 19. WAS AUTOPSY PERFORMED? YES NO 200. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part 1 or Part 11 of item 18.) 20c. TIME OF INJURY Month, 20e. PLACE OF INJURY (Home, farm, 20f. (City or town) Day, Year 20d. INJURY OCCURRED (Caunty) (State) factory, street, affice bldg., etc.) Hour a. m. While Not while at wark ot work 1- 1957, that I last saw the deceased 21. I certify that I extended the deceased from and that death accurred at M, from the causes and an the date stated above. ACTUAL 220. BURIAL CREMATION, 22b. DATE THEREOF 22c. NAME OF CEMETERY OR CREMATORY 22d. LOCATION (City, town, or county) (State) REMOVAL (Specify) 23. FUNERAL DIRECTOR'S SIGNATURE **ADDRESS** 240. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE

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MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18 11270

CERTIFICATE OF DEATH

1. PLACE OF DEATH o. COUNTY	Carroll		MARYLA	- 11	USUAL RESIDENCE (Vo. STATE	Where deceosed	d lived. If institut b. COUNTY			admission)
b. CITY OR TOWN (I RURAL and give no WOOD)	f outside corporate limits corest town) INE	, write c. I	10 WKS	1 1b	c. CITY OR TOWN (IF		rote limits, write l minster		ve neares	t town)
d. NAME OF HOSPIT OR INSTITUTION	Neitzel Nu	re street addr	Home	1	at Win	nfield				IS RESIDENCE ON A FARM? ES NO
3. NAME OF DECEASED (Type or print)	mil	ù	L Middle	12	chet	4. DATE OF DEATH	Mo		Day 1 7	Year 19 50
5. SEX female	6. COLOR OR RACE	7. MARRIED			6-17-1900)	9. AGE (In years lost birthdoy) 59 yrs.	IF UNDER 1		UNDER 24 HRS
house	ON (Give kind of work do		O OF BUSINESS OR I	INDUSTRY	11. BIRTHPLACE (Stol	le or foreign co	11		S.	HAT COUNTRY
3. FATHER'S NAME	Harry G	osnel	1		4. Mother's Maiden Marian G	osnel	1			
15. WAS DECEASEDEVE (Yes, no, or unknown)	R IN U. S. ARMED FORC (If yes, give war or dates of ser	vice)	14-1638		Merbert	Pick		ress ame		
	TH [Enter only one cou TH WAS CAUSED BY:	se per line for	11/4 - 1	1/1	to 1 Sch	1 ~0. 4			INTERV	AL BETWEEN AND DEATH
356.1 Conditions, if o		Carlo	live fail	ur,	ansır	Cir,	Sangene	me	19.	56 50
gove rise to in couse (o), stating lying couse lost.		aleu	on des	Atra	ch x lip	. an	lentia		170	oct sq
CATIC	IER SIGNIFICANT COND	ITIONS <u>CONT</u>	RIBUTING TO DEATH	H BUT NO	T RELATED TO THE TERM	MINAL DISEASI	E CONDITION GI	EN IN PART	F	WAS AUTOPSY PERFORMED? ES NO
(IF EITHER, NOTIFY	S UNDERLYING CAUSE OF DEATH MEDICAL EXAMINER)	06. DESCRIBE	HOW INJURY OCC	URRED. (E	inter noture of injury in	n Port I or Port	I II of item 18.)			113
20c. TIME OF INJUR Hour o. m. p. m.	Y Month, Doy, Year	While	Y OCCURRED 20 Not while of work	e. PLACE foctory	OF INJURY (Home, far , street, office bldg., e	rm, 20f. (City	or town)	(Co	ounty)	(Stote
21. I certify the alive an	at I attended the	deceased f		9 59 eath ac	, 19 , to /			d on the		
ACTUAL SIGNATURE	Down	16	Hace	M.D	Ache	ADDRESS (SI	reet, city or town,	stote)	1	SOUTS!
PHYSICIAN'S I	HOWARD E.	HALL								
220. BURIAL, CREMATIO REMOVAL (Specify) BUR IAL	N, 22b. DATE THEREOF		Morgan				Oll Co.			(Stote)
23. FUNERAL DIRECTOR' C . M .			ADDRESS		24a. REC	OCT 21	RAR 24b. REG	STRAR'S SIGI		4

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CALLED ON THE CALL THE TOTAL CONTINUE OF CALLED ON CALL THE CALL T	way be retained by the hospital ar attending physician.	H 01	Dd.	the registrar part to burial, cremation, or remaval, and in any event within 72 hours after death.	

1. PLACE OF DEATH o. COUNTY

MARYL 11271	AND Iter	STATE DEPAR 1 FilmG25 CERTIF	TMI	ENT OF HEALTH 11-13-59 et ATE OF DEATH	—BAL	TIMORE, 1	8 Reg. D		112	52	
الم		MARYLA	ND	2. USUAL RESIDENCE (When STATE	ere decease	d lived. If institution b. COUNTY	on: Reside	12	re admiss	./	
outside corporate limit prest town)	s, write	c. LENGTH OF STAY IN	16	Bal timore	otside corpo		JRAL ond		rest lowr	n)	
L (If not in hospital, gi				d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES \(\text{NO} \) NO \(\text{E} \)							
Firs		Middle Malco	olm	Lost PYLE	4. DATE OF DEATH	Mon Octo	_	00	_	Yeor 19 59	
6. COLOR OR RACE White		DIVORCED		3-12-1879	Months	Days	Hours	ER 24 HRS. Min.			
N (Give kind of work d ng life, even if retired) Engineer	one 10b.	KIND OF BUSINESS OR	NDUS	otry 11. Birthplace (Stole of Maryla:		ountry)	12. CI	TIZEN O		COUNTRY?	
Westlev Pv	le			14. MOTHER'S MAIDEN N. Aman		Comas					
IN U. S. ARMED FORG yes, give wor or dates of se	ES2 16.	SOCIAL SECURITY NO.		epords of Spr	ingfi	Addr eld State		pita	1.		
H [Enler only one cou	se per li	ne for (o), (b), and (c).]						INT	RVAL BE	TWEEN	

	Carr	roll	1.0	MAKTCAN	10	Manuel	and			141	2874	125C.01	
	b. CITY OR TOWN I	outside corporate limit	s, write	c. LENGTH OF STAY IN	1b	c. CITY OR TO	OWN (If ou	tside corpor	ote limits, write	RURAL ond	d give ne	arest low	1)
	Sykesvi			1M 2OD		Dall	mre			3 x			
		AL (If not in hospital, gi	ve street o	oddress)		d. STREET AD	DRESS			- /-	(C)(A) yes	e. IS RES	IDENCE FARM?
L		eld State H	losni	tal		3222 Pu	tty F	H111 R	oad				NO:
3.	NAME OF DECEASED	Firs	ı	Middle	7-1-1	Lost		4. DATE OF		onth	Do	ру	Yeor
	(Type or print)	Ro	bert	Malco	lm	PY	LE	DEATH	Oct	ober		31	19 59
5.	SEX	6. COLOR OR RACE	7. MARR	IED NEVER MARRIED] B. D.	ATE OF BIRTH	. 0 = 0		9. AGE (In year last birthdoy)	IF UNDE			ER 24 HRS.
	Male	White	WIDOWE	DIVORCED		3-12-	1879		80 %	Months	Days	Hours	Min.
10	o. USUAL OCCUPATION	ON (Give kind of work ding life, even if retired)	one 10b.	KIND OF BUSINESS OR IN	NDUSTRY	11. BIRTHPLA	CE (Stote o	or foreign co	untry)	12. C	ITIZEN C	OF WHAT	COUNTRY?
1	Stationary	engineer	A.			Ma	aryla	nd			US	SA	
	FATHER'S NAME				14	4. MOTHER'S	MAIDEN N	AME					
	Charles	Westley Pv	a				Aman	da McC	Comas				
	. WAS DECEASED EVE	R IN U. S. ARMED FOR	CES? 16.	SOCIAL SECURITY NO. 1	7. INFO	RMANT			Ac	ldress			
(1	es, no, or unknown)	(If yes, give war or dates of se	rvice)		Rep	ords of	Spr:	ingfie	eld Stat	e Hos	pita	11	
=	18. CAUSE OF DEA	TH [Enler only one cou	use per lin	ne for (o), (b), and (c),]							LINT	ERVAL BE	TWEEN
F		ATH WAS CAUSED BY:							ON	5 days			
	11200	IMMEDIATE CAUSE (0)		Dronenopme	UIIIOII	TS.					- 2	aay	\$
	420.0												
		(b) Arteriosclerotic heart disease incl.coron.disease											
	couse (o), stoting		,	Uman a a base a mid a		- (1	e to	malio	mancy?)				
,	lying couse lost.) (c)		Hypochromic									
CERTIFICATION	PART II. OTH			ONTRIBUTING TO DEATH							RT 1(0)	19. WAS PERFC	AUTOPSY DRMED?
2	CBS as			l arterioscl						on		YES D	NO 🗍
RTIE	OR CONTRIBUTING	CAUSE OF DEATH	20b. DESC	TRIBE HOW INJURY OCCU	JRRED. (E	nter nature of	injury in P	ort I or Part	II of item 1B.)				
		MEDICAL EXAMINER)											
MEDICAL	20c. TIME OF INJUR	Y Month, Day, Yea	r 20d. IN While	JURY OCCURRED 20e	foctory.	OF INJURY (H , street, office	ome, form, bldg., etc.)	20f. (City	or town)		(County)		(Stote)
ME	p. m.	19		of work									
	21. I certify th	at I ottended the	decease	ed from 10-	6	_, 1959	, to	10-31	19 5	9. that I	l last s	aw the	deceased
	olive an			59, and that de									
	0.	D		J					reet, city or tow		THE GC		ATE SIGNED
	ACTUAL	Misson M	liss	whower	44.0	Spri	nafia	ale St	ate Hos	mital		77	-1-59
	SIGNATURE	1	1	X	M.U.		h di degishiribi S	F-1-12.	STATE THE	hrran			-1-27
	PHYSICIAN'S NAME (Type)	Myron Nyz	ankov	vski O		Sy	kesv	ille,	Marylar	ıd			
22	o. BURIAL, CREMATIO REMOVAL (Specify)			22c. NAME OF CEMETER				22d. LOCAT	ION (City, town	, or county)	(Stot	e)
	Burial	11-4-59	9	Parkwood	Ceme	etery.		Balt	imore.	Md.			
23	FUNERAL DIRECTOR			ADDRESS	V		24a. REC'D	BY REGISTI		SISTRAR'S S	GNATU	RE	
	Wm.Cool	Blight In	c. 60	009 Harford	Rd.	14.	DATEVOV	3 '59	0	Ilun 8	4		
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MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

CERTIFICATE OF DEATH

	1127	2	CERTIFICA	ATE OF DEAT	Н	Reg. Dist.	. No.
PLACE OF DEATH	arroll		MARYLAND	2. USUAL RESIDENCE (W	Where deceased lived. If institution b. COUNTY		to.City
Sykesvil	le		c. LENGTH OF STAY IN 16		outside corporote limits, write R	SURAL and giv	ve nearest town)
OR INSTITUTION	eld State H			d. STREET ADDRESS	N. Calvert St.		e. IS RESIDENCE ON A FARM? YES NO
3. NAME OF DECEASED (Type Or print)	Gust		Middle Ref	inhardt	4. DATE Mor		Doy Year 5, 19 59
5. SEX Male	6. COLOR OR RACE White	7. MARRI WIDOWE	DIVORCED DIVORCED	B. DATE OF BIRTH August 28, 1	9. AGE (In years last birthdoy) 94 yrs.		YEAR IF UNDER 24 HR. Days Hours Min.
Po. USUAL OCCUPAT during most of wo Carpent	irking life, even if retired	dane 10b.)	CIND OF BUSINESS OR INDU	STRY 11. BIRTHPLACE (Stot			en of what country uralized
3. FATHER'S NAME Andrew	Reinhardt			14. MOTHER'S MAIDEN Minnie	Reinhardt		
15. WAS DECEASED EV {Yes, no. or unknown}	'ER IN U. S. ARMED FOR (If yes, give war or dates of s	ervice)		nformant Springfield H	lospital Record		
	ATH [Enter only one co ATH WAS CAUSED BY: IMMEDIATE CAUSE (c		e for (o), (b), ond (c).]				INTERVAL BETWEEN ONSET AND DEATH Days
Conditions, if gove rise to cause (o), stoting	immediate (Ar	terioscleroti	c heart disea	ase	3)	Years
PART II. O	ther significant control the senile b	rain	disease with p	sychotic res		VEN IN PART	1(o) 19. WAS AUTOPSY PERFORMED? YES NO
OR CONTRIBUTION	/AS UNDERLYING ☐ G ☐ CAUSE OF DEATH Y MEDICAL EXAMINER)				n Port I ar Part II of item 18.)	tell	
20c. TIME OF INJU Hour o. m. p. m.		ar 20d. IN While of work	Not while fa	ACE OF INJURY (Home, for ctory, street, office bldg., e		(Co	ounty) (Stote
actual SIGNATURE		12.5 alk	9, and that death	accurred at 8:20F	M, fram the causes ar ADDRESS (Street, city or town, eld State Hospi le, Maryland	nd an the	
220. BURIAL, CREMATI	ON, 22b. DATE THEREO)F	22c. NAME OF CEMETERY C	R CREMATORY	22d. LOCATION (City, town, 5829 Ritchie		(State)
23. FUNERAL DIRECTO	R'S SIGNATURE		ADDRESS 7 St. Paul S.	24o. REC	TO BY PEGISTRAP 245 PEGI	STRAR'S SIGN	

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

	MARYLAN	D STATE DEPART	MENT OF H	EALTH-BA	LTIMORE, 18	4.1	054
	11273	CERTIFI	CATE OF I	DEATH		Reg. Dist. No.	254
1. PLACE OF DEATH a. COUNTY	011	MARYLAN	I O STATE	DENCE (Where deceas	ed lived. If institution b. COUNTY	Residence before o	dmission)
b. CITY OR TOWN (If outs RURAL and give nearest		c. LENGTH OF STAY IN		TOWN (If outside corp	orote limits, write RUR		tawn)
d. NAME OF HOSPITAL (IF OR INSTITUTION	not in hospital, give stre	et oddress)	d. STREET A	MAIN			RESIDENCE ON A FARM? ES NO
3. NAME OF DECEASED (Type or print)	Rachel	Middle	Roesei	4. DATE OF DEATH	Gotober	Day 31	Yeor 19 5 9
Female a	shite wido	RRIED NEVER MARRIED [April	1,1864			ours Min.
	ive kind of wark dane 10 fe, even if retired)	HOME	7	ACE (Stote ar foreign	country)	12. CITIZEN OF W	VHAT COUNTRY?
13. FATHER'S NAME	Huusbe	ery	Elv	ga Per	ming	tou	
15. WAS DECEASED EVER IN L (Yes, no, or unknown) (If yes,	J. S. ARMED FORCES? 1 give war ar dates of service)	6. SOCIAL SECURITY NO.	Mrs Mar	y Willian	Addres MA	MPSTER	p Md
PART I. DEATH W		line for (a), (b), and (c).	Myoc	arditis			AL BETWEEN AND DEATH
Canditians, if any, w gove rise to immed code (a), stoting the w lying couse last.	diote	rknie sclo	retie Ca	rcio-Vasc	ular Dis	ease ?	
PART 11. OTHER SI		S CONTRIBUTING TO DEATH	BUT NOT RELATED TO	THE TERMINAL DISEA	SE CONDITION GIVEN	P	VAS AUTOPSY ERFORMED?
PART II. OTHER SI	DERLYING 20b. D AUSE OF DEATH CAL EXAMINER)	ESCRIBE HOW INJURY OCCU	JRRED. (Enter nature o	of injury in Port 1 or Po	ort II af item 18.)		
20c. TIME OF INJURY M Haur a. m. p. m.	Whi		foctory, street, offic	Home, form, 20f. (Ci e bldg., etc.)	ty or town)	(County)	(Stote)
21. I certify that I alive an actual SIGNATURE				3:30 M, fro	m the causes and Street, city or town, sto	d an the date :	
PHYSICIAN'S SO	seph E. K	Bush M	0 1	Shipsta	AD Mar	yland	
220. BURIAL CREMATION, 2 MOVAL (Specify)	26. DATE THEREOF 7	22c. NAME OF CEMETER	RY OR CREMATORY Ridg	e Pe	AJION (City, town, or	e Me	(State)
23. EUNERAL DIRECTOR'S SIG	intou !	Haupstean	1 mil	24a. REC'D BY REGI	100 /4	PAR'S SIGNATURE	14

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the haspital ar attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and campletely filled in page 3 shapes to be a second of the propers. Pages 1 of the registration of the propers. VS A15 (4) 15M 9/55

the funeral director, should be filed with

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MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18 11274

CERTIFICATE OF DEATH

11255

Reg. Dist. No.

	o. COUNTY Carroll	MARYLAND	o. STATE Maryl	b. COUNTY	Washington	
	b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville	c. LENGTH OF STAY IN 16	c. CITY OR TOWN (If ou Hagersto	tside corporote limits, write RURA	21.03.2	
	d. NAME OF HOSPITAL (If not in hospital, give street OR INSTITUTION Springfield State Hos	oddress) pital	d. STREET ADDRESS	dway Ave.	e. IS RESIDENCE ON A FARM? YES NO	
	3. NAME OF DECEASED (Type or print) Benjami	Middle	Schaff	4. DATE Month OF DEATH October		
	5. SEX Male 6. COLOR OR RACE 7. MAR WIDOW		November 15,	9. AGE (In years lost birthdoy) 71 yrs.	UNDER 1 YEAR IF UNDER 24 HRS. onths Days Hours Min.	
	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tool & Dye Maker 13. FATHER'S NAME	KIND OF BUSINESS OR INDU	STRY 11. BIRTHPLACE (SION O Maryl 14. MOTHER'S MAIDEN NA	and	12. CITIZEN OF WHAT COUNTRY?	
	Stover S. Schaff		Maggie C.	Mowen	7 17 4 1 1 7 7 0	
	(Yes, no, or unknown) (If yes, give war or dates of service)	14-09-4940-A	NFORMANT Springfield H	ospital Records		
	1B. CAUSE OF DEATH [Enter only one couse per I PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o)	ine for (o), (b), ond (c).]		4/	INTERVAL BETWEEN ONSET AND DEATH	
	gove rise to immediate couse (o), stating the under-	teriosclerotic)	Years	
	PART II. OTHER SIGNIFICANT CONDITIONS C.B.S. assoc. with cerebra Old infarct in right sic 200. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CONTRIBUTING CONTRIBUTING CONTRIBUTING CONTRIBUTING (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DES	CONTRIBUTING TO DEATH BUT Larteriosclar le of brain due	NOT RELATED TO THE TERMIN osis without of to arteriosc	ualifying phras	IN PART 1(a) 19. WAS AUTOPSY	
	Hour o.m. While	Not while fo	ACE OF INJURY (Home, form, ctory, street, office bldg., etc.)	20f. (City or town)	(County) (State)	
21. I certify that I attended the deceased fram. July 17, 1959, to October 25, 1959, that I last saw the dalive on October 25, 1959, and that death accurred at 1:15P M, fram the causes and an the date stated ADDRESS (Street, city or town, state) ACTUAL SIGNATURE Courts del Compo M.D. Springfield State Hospital 10/2 PHYSICIAN'S NAME (Type) Agustin delCampo, M.D. Sykesville, Maryland						
	220. BUBIAL, CREMATION, 1/22b. DATE THEREOF	22c. NAME OF CEMETERY CO	e CREMATORY :	22d. LOCATION (City, town of c	ounty) (State)	
	23. FUNERAL DIRECTOR'S SIGNATURE	+ apristou	W MARTE DATE		AR'S SIGNATURE	

TO FUNERAL PARC page 3 shave VS A15 (4) 15M 9/58

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VS A15 (4) 15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11275 CE

CERTIFICATE OF DEATH

1. PLACE OF DEATH G. COUNTY Carroll		7		MARYLAND	a. STATE	DENCE (W	all and the	d lived. If institu b. COUNT Ba				sian)
b. CITY OR TOWN RURAL and give Sykesvi	(If autside carporate limi nearest tawn)	ts, write		th of STAY IN 16	_	TOWN (IF	0.000	orate limits, write	RURAL and	,	rest taw	n)
d. NAME OF HOSP	ITAL (If not in hospital, geld State H	ive street	address)	uays	d. STREET	ADDRESS	bons A	ve.	5 4 0	-	ON	SIDENCE A FARM?
3. NAME OF DECEASED (Type ar print)	Fir HS	NRY		Middle GOTTLIE	B SCHM		4. DATE OF DEATH		nth_ ober	Day 8		Year 19 59
5. SEX	6. COLOR OR RACE	7. MARI		DIVORCED	B. DATE OF BIRT			9. AGE (In years last birthday) yrs	Manths	Days	Haurs	ER 24 HRS Min.
10a. USUAL OCCUPAT during most of wo Printe	ION (Give kind of wark irking life, even if retired			BUSINESS OR INDI		rylan		ountry)	12.C	U.S.		COUNTRY
13. FATHER'S NAME					14. MOTHER'S					8		
Jacob	Schmidt					abeth	Fisch					
15. WAS DECEASED EV	ER IN U. S. ARMED FOR (If yes, give war or dates of s		SOCIAL SI		INFORMANT				dress			
		2	13-0	3-3134R	ecords,	Sprin	gfield	State H	ospi	tal		
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actual signature	hat I attended the cober 8	10 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	Car	September and that deat upo	h occurred at	4:40 ingfi	And fram Address (Sield St		nd on ti	he date	stated	
22a. BURIAL, CREMATI REMOVAL (Specification)	ON, 22b. DATE THEREO	59	1	ME OF CEMETERY	111	2.um	0	TION (City, town,	M	d.	(Sta	te)
23. FUNERAL DIRECTO	0 0 1	05 t	ADD	ord Rd		1	OCT 1 3			SIGNATUR		

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VS A15 (4) 15M 10/57

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 11276

CERTIFICATE OF DEATH

11257

1. PLACE OF DEATH O. COUNTY AKKELL MARYLAND	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE b. COUNTY Paralle
b. CITY OR TOWN (If outside corporate limits, write RURAD and give nearest town)	c. CITY OR TOWN (If autside corporate limits, write RURAL and give nearest tawn)
d. NAME OF HOSPITAL (If not in haspital, give street address) OR INSTITUTION	d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES NO
3. NAME OF DECEASED (Type or print) HORACE L. Middle	PLEY 4. DATE Month Day Year OF DEATH OCTOBER 2, 1959
5. SEX 6. COLÓR OR RACE 7. MARRIED NEVER MARRIED DIVORCED DIVORCED	8. DATE OF BIRTH 9. AGE (In years last birthday) wonths Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR INDU during most of working life even if retired)	STRY 11. BIRTHPLACE (State or foreign country) 12. CITIZEN OF WHAT COUNTRY 12. CITIZEN OF WHAT COUNTRY
13. TATHER'S NAME Shipley	Mistine Combusight
15. WAS DECEASEDEVER IN U. S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. It (Yes, no. or unknown) (If yes, give wor or dates of service)	NFORMANT Address Address Menkeling me
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO	MARRAGE INTERVAL BETWEEN ONSET AND DEATH
Canditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ARC/NOM A DUE TO	OF RECTUM UNKNOWN
(6)	NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) 19. WAS AUTOPSY
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT ARTERIO SCLEROTIC. C. V	DISERSE YES NO DE
	D. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Manth, Day, Year 20d. INJURY OCCURRED to the p. m. 19 at work at work to the p. m.	ACE OF INJURY IHome, form, 20f. (City or town) (County) (State) ctory, street, affice bldg., etc.)
21. I certify that I attended the deceased from Sept. 2 alive an Collection, 1959, and that death	accurred at 2:30 P.M. from the causes and on the date stated above ADDRESS (Street, city or, town, state) DATE SIGNE
SIGNATURE MARTIN E. Straig	M.D. 48 MAIN ST. NEISTERSTOWN 10/24
PHYSICIAN'S MARTIN E. STROBEL	MARYLAND
220. BURIAL, CREMATION, 22b. DATE THEREOF 22c. NAME OF CEMETERY OF PROVIDED 10-5-59 MOVEDLE	R CREMATORY 22d. LOCATION (City, town, or county) (State)
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS ADDRESS ADDRESS	240. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE DATE CT 5 2 '59 Continued & Known

No 2 3	BI BROWITAL HELAIN TO THEALTHASE STATE ORATINAM				
3	CERTIFICATE OF BEATH	11216			
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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 1127MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11258

					Keg. Dist. 140	/•
1. PLACE OF DEATH			2. USUAL RESIDENCE (V	Where deceased lived. If Instit	ution: Residence be	fore admission)
	Carroll	MARYLAND	Mar	vland "Con	Carroll	
and give necrest tow	(If outside corporate limits, write RUR		c. CITY OR TOWN (II	outside corporate limits, writ	RURAL and give n	earest town)
rural	Sykesvill	e Life	X rural-	-Sykesville		
d. NAME OF HOSPI	TAL OR INSTITUTION (If no	in hospitol, give street address)	d. STREET ADDRESS Buckho:	rn Rd.		e. IS RESIDENCE ON A FARM? YES NO
3. NAME OF DECEASED (Type or print)	First MATILDA	A. SHI	Lost PLEY	4. DATE OF MON	th Day	Year 1959
5. SEX	6. COLOR OR RACE 7.	MARRIED NEVER MARRIED 🔣 8	. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER TYEAR	IF UNDER 24 HRS.
female	white w	DOWED DIVORCED	3-27-189	7 62 yrs.	Months Days	Hours Min.
100. USUAL OCCUPAT	ON (Give kind of work done	10b. KIND OF BUSINESS OR INDUST	RY 11. BIRTHPLACE (Stote	or foreign country)	12. CITIZEN O	F WHAT COUNTRY
Teach	ing life, even if retired)	school	Marylan	nd	U.	S.
13. FATHER'S NAME			14. MOTHER'S MAIDEN I		-	
	Almer Ship	lev	Mary Jan			570
15. WAS DECEASED EV			NFORMANT	Addres		4
(Yes, no, or unknown)	(If yes, give war or dates of service)	iss Lillian		Vestmins	ton Md
no	ATH Enter only one cause po		TOS PITITIO	n purbrea,		IVAL SETWEEN
	ATH WAS CAUSED BY:	(c), (b), ond (c).	=:0			ET AND DEATH
101	IMMEDIATE CAUSE (o)	Caracac 1	accure		2	orscray
421.	DUE TO	100 0 . 16	ent Dia	0-0	100	LUPALS
Conditions, if a		Vacoucar 11	(20)			7 - 0
(o), stoting the						
couse last.) (c)					
PART II. OT	Diabete	ONS CONTRIBUTING TO DEATH BUT N	OT RELATED TO THE TERM	INALDISEASE CONDITION GI		P. WAS AUTOPSY PERFORMED? YES NO
20g. EXTERNAL CA PRIMARY OF OF CAUSE OF DEATH	INTRIBUTING [ESCRIBE HOW INJURY OCCURRED. (E	nter noture of injury in Por	t I or Port II of item 18.)		
20c. TIME OF INJU	JRY Month, Day, Year		CE OF INJURY (Home, form	20f. (City or town)	(County)	(Stote)
Hour o. m.		While Not while focts	appetreet, office bldg., etc.	,		
_		the remains described obo	ve. held on Autons	v 🗍 Inspection 🖾	Inquiry 🗆	, and find tha
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ACTUAL SIGNATURE	Julius C	hepker	M.D. CHIEF MEDICAL EX	KAMINER []		DATE SIGNED
SIGNATURE	1		M.U. ASSISTANT MEDIC	AL EXAMINER [7]		0/17/
EXAMINER'S NAME (Type)		НЕРКО	DEPUTY MEDICAL			123/34
220. BURIAL, CREMATIC REMOVAL (Specify	ON, 22b. DATE THEREOF	22c. NAME OF CEMETERY OR		22d. LOCATION (City, town.		(Stote)
BURIAL	10-24-19	R-A-	r	Carroll Co.		
23. FUNERAL DIRECTOR C. M.	r's signature Waltz.	Winfield, Md.			ISTRAR'S SIGNATUL	
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VS. A1SME(5) 5M 9/55

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CERTIFICATE OF DEATH

	1. PLACE OF DEATH o. COUNTY Carroll	MARYLAND	2. USUAL RESIDENCE (V o. STATE Max		. COUNTY	ce before admission)
-	b. CITY OR TOWN (If autside carparate limits, write RURAL and give nearest tawn) Sykesville	c. LENGTH OF STAY IN 16	Hage	fautside carporate linerstown R#2	nits, write RURAL and g	21x-2
5	d. NAME OF HOSPITAL (If not in hospital, give street OR INSTITUTION Springfield State Hospit		d. STREET ADDRESS			e. ts residence ON A FARM? YES NO
	3. NAME OF DECEASED (Type or print) Fred First	Middle	Sprecher	4. DATE OF DEATH	October	Day Year 13, 19 59
	5. SEX Male 6. COLOR OR RACE 7. MARI		July 2, 187	d look	Link In A	1 YEAR IF UNDER 24 HRS. Days Haurs Min.
	SUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer STATHER'S NAME	KIND OF BUSINESS OR INDUS	Marylan 14. MOTHER'S MAIDEN	ıd		ZEN OF WHAT COUNTRY?
	J. Irwin Sprecher		Annie E	Bowles		
	15. WAS DECEASED EVER IN U. S. ARMED FORCES? 16. (Yes, no, or unknown) (If yes, give war or dates of service)	0/0 0/-	offormant pringfield H	lospital Re	Address ecords	SE III
	Canditians, if any, which gave rise to immediate cause (a), stating the under-lying cause last.	cinoma of the onchi and pelv tiple lung abs	ic tissue cesses with	bronchopne	eumonia	Months: Weeks
2	C.B.S. assoc. with cere		lerosis with	psychosia	3.	PERFORMED? YES NO
	20c. TIME OF INJURY Manth, Day, Year 20d. I Haur a. m. 19 While p. m. 19	Nat while fac	ACE OF INJURY (Hame, fa tary, street, affice bldg., e	etc.)		Caunty) (State)
/	21. I certify that I attended the decease alive an October 13, 195 ACTUAL SIGNATURE COMMANDE OF AGUSTIN delCamp PHYSICIAN'S NAME (Type) Agustin delCamp	2 and that death	accurred at 6:50		auses and an the ity ar tawn, state) tal	st saw the deceased date stated above. DATE SIGNED 10/11/59
	22a. BUBIAL, CREMATION 22b. DATE THEREOF	22 NAME OF CEMETERY OF STATES ADDRESS	furch	22d. LOCATION (C'D BY REGISTRAR	City+tawn, ar county) LUMBA 24b. 9EGISTRAR'S SIG	

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VS A15 (4) 15M 9/55 5 & A

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 1	18
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11279 CERTIFICATE OF DEATH

Reg. Dist. No. 126()

o. COUNTY Carrol1	MARYLAND	o. STATE Mary land	b. COUNTY	Carroll
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest lawn) Rural, Westminster	c. LENGTH OF STAY IN 16	c. CITY OR TOWN (If outside	corporole limits, write RURAL on stminster	nd give n'earest town)
d. NAME OF HOSPITAL (If not in hospitot, give street of OR INSTITUTION Westminster, Md. R. D. 1	oddress)	/ d. STREET ADDRESS Westminste:	r, Md. R. D. 1	e. IS RESIDENCE ON A FARM? YES NO
3. NAME OF First DECEASED (Type or print) Fannie	Maude Maude		DATE Month OF October	Doy Yeor 13 19 59
Female White WIDOWE	D DIVORCED	8. DATE OF BIRTH 4/23/1889	70 yrs. Month	S Days Hours Min.
	her own home	Carroll Co.,		U.S.A.
3. FATHER'S NAME Washington Myers		14. MOTHER'S MAIDEN NAME Mary Jane		
S. WAS DECEASEDEVER IN U. S. ARMED FORCES? 16. (Yes. no. or unknown) (If yes, give war or dates of service)		NFORMANT	Address r, Westminster,	Md. R.D.1
Conditions, if ony, which gove rise to immediate couse (a), stating the underlying couse tast. Part II. OTHER SIGNIFICANT CONDITIONS C	ONTRIBUTING TO DEATH BUT	NOT RELATED TO THE TERMINAL C	DISEASE CONDITION GIVEN IN P.	ART 1(a) 19. WAS AUTOPSY PERFORMED? YES NO NO
OR CONTRIBUTING LI CAUSE OF DEATH	RIBE HOW INJURY OCCURRED	D. (Enter nature of injury in Part I	or Part II of item 18.)	7
Hour o. 11. While	Not while of work	CE OF INJURY (Home, form, lary, street, office bldg., etc.)	f. (City or lawn)	(County) (State)
21. I certify that I attended the decease alive an Oct. 13 19.	ed from Signt Sq., and that death Lunk		from the causes and an iESS (Street, city or town, state)	I last saw the deceased the date stated above. DATE SIGNED
PHYSICIAN'S NAME (Type)		100000000000000000000000000000000000000	, , ,	
20. BURIAL CREMATION, REMOVAL (Specify) BURIAL 10/16/59	22c. NAME OF CEMETERY OF Pleasant Val		LOCATION (City, town, or county 1easant Valley,	
23. EUNERAL DIRECTOR'S SIGNATURE	ADDRESS Littlestown	240. REC'D 8Y	REGISTRAR 24b. REGISTRAR'S	SIGNATURE

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

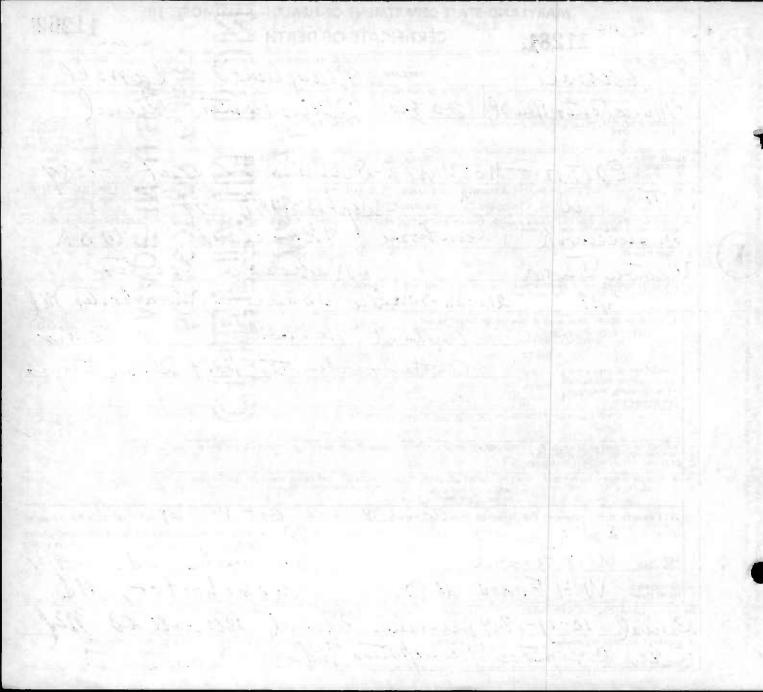
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1. PLACE OF DEATH a. COUNTY	noll	MARYLAND	2. USUAL RESIDENCE (Wh.	ere deceased lived. If ins b. COU		fare admission)
b. CITY OR TOWN (If RURAL and give ned	1 - 1 4 \ - 1 /	c. LENGTH OF STAY IN 16	c, CITY OR TOWN (IF O	utside carporate limits, wr	ite RURAL and give n	1/
d. NAME OF HOSPITA OR INSTITUTION	L (If not in haspital, give street	address)	d. STREET ADDRESS			e. IS RESIDENCE ON A FARM? YES NO
3. NAME OF DECEASED (Type or print))/TH =M	ELVINIA	-SULL'UAN	4. DATE OF DEATH	Manth 8 -	001/9519 Year
S. SEX	6. COLOR OR RACE 7. MARE WIDOWI	RIED NEVER MARRIED DIVORCED DIVORCED	B. DATE OF BIRTH	AT 9/ 9. AGE (In your last birthd)		AR IF UND R 24 HRS. Haurs Min.
10a. USUAL OCCUPATION during mast af warking	ig life, even if retired)	Seve how	DUSTRY 11. BIRTHPLACE (State of Muleus)	or fareign country)	12.CITIZEN	OF WHAT COUNTRY?
13. FATHER'S NAME	Frock		14. MOTHER'S MAIDEN	AME L	cister	
	N. U. S. ARMED FORCES? 16.	SOCIAL SECURITY NO. 6-38-3012	INFORMANT LEW W Soull	Levan, M	aurles	Ter med
PART I. DEAT	H [Enter anly ane cause per line H WAS CAUSED BY: IMMEDIATE CAUSE (a)	ne for (a), (b), and (c).]	e Hemor	rhose		SET AND DEATH
Conditions, if on gave rise to im cause (a), stating the lying cause last.	mediate (artem	ordenti	· Heart	Riseare	5 yrs
CATIC	R SIGNIFICANT CONDITIONS (CONTRIBUTING TO DEATH B	UT NOT RELATED TO THE TERMII	nal disease condition	GIVEN IN PART 1(a)	19. WAS AUTOPSY PERFORMED? YES NO 12
20a. ACCIDENT WAS OR CONTRIBUTING [(IF EITHER, NOTIFY A	UNDERLYING A 20b. DES	CRIBE HOW INJURY OCCUR	RED. (Enter nature of injury in P	art I ar Part II af item 18	.)	
20c. TIME OF INJURY Haur a. m. p. m.	While		PLACE OF INJURY (Hame, farm, factory, street, office bldg., etc.		(Caunty	y) (State)
C	t l attended the deceas		18 , 19 50, to Q	et 8, 19	57, that I last so	aw the deceased
ACTUAL SIGNATURE	11/ Frown	之, and that dea	1.0	M, fram the causes ADDRESS (Street, city or to		te stated above DATE SIGNED
PHYSICIAN'S NAME (Type)	N.H FOAR	d M.D	M	Anches	ter	Ud.
BEMOVAL (Specify)	226. DATE THEREOF.	Pennale	OR CREMATORY LEformed	22d. LOCATION (City, to	el lo	Wistore)
23. EUNERAL DIRECTOR'S	SIGNATURE	Waluhi	tead of 240. REC'T		REGISTRAR'S SIGNAT	



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11282 CERTIFICATE OF DEATH

	11404					Keg. I	DIST. 140.	
1. PLACE OF DEATH o. COUNTY Cal	roll	MARYLA		JSUAL RESIDENCE (W s. STATE Maryl		If institution: Resid		dmission)
b. CITY OR TOWN (If outs RURAL and give neorest rural Syk	town)	c. LENGTH OF STAY IN 6 mo.	1 1b	c. CITY OR TOWN (IF	Sykesvi]	nits, write RURAL and		town)
d. NAME OF HOSPITAL (IF	not in hospital, give stre rivate Home		1	d. STREET ADDRESS			0	RESIDENCE ON A FARM? S NO
3. NAME OF DECEASED (Type or print)	First ALBERT	Middle	THOM	Last [AS	4. DATE OF DEATH	Manth OCT.	25.	Year 19 59
		ARRIED NEVER MARRIED	270	TE OF BIRTH	lost	E (In years IF UNDI hirthday) Manths	Days Ho	NDER 24 HRS.
10a. USUAL OCCUPATION (Goduring most of working line farm labor	ife, even if retired)	ob. KIND OF BUSINESS OR farming	INDUSTRY	11. BIRTHPLACE (State	e or fareign country)	12. C	U.S.	AT COUNTRY?
13. FATHER'S NAME	orge Thom	as	14	MOTHER'S MAIDEN	_			
15. WAS DECEASED EVER IN			Mrs.		Cook, Co	Address	e, Md.	
Canditions, if any, v gove rise to imme- cause (a), stating the <u>u</u> lying couse last.	AS CAUSED BY: LEDIATE CAUSE (a) DUE TO which (b) diate (nder-) DUE TO (c)	Augusting to DEAS	ture	al Hes al Cesi A As	north hallr terro	leng	ONSET	AS AUTOPSY
20g. ACCIDENT WAS UN OR CONTRIBUTING C	IDERLYING 20b. E	DESCRIBE HOW INJURY OCC	ru	ular	Con	delin	PI	ERFORMED?
20c. TIME OF INJURY M Hour o. m. p. m.	Wh		0e. PLACE of factory,	DF INJURY (Hame, fare street, affice bldg., et	m, 20f. (City or tax	vn)	(County)	(State)
(1)	RELL N. M	3 //.	leath acc	, 195 9, to Courred at 109				
22a. BURIAL, CREMATION, 2 REMOVAL (Specify) BURIAL	10-28-195	22c. NAME OF CEMET		MATORY		City, town, ar caunty	-	(State)
23. FUNERAL DIRECTOR'S SIG	NATURE WI	nfiêld, Md	•	24a. REC	OCT 28 '59	24b. REGISTRAR'S	SIGNATURE 1 8. Krau	A

VS A15 (4) 15M 10/57 M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11283

CERTIFICATE OF DEATH

11264

71700				Reg. Dist, No.
o. COUNTY Carroll	MARYLAND	2. USUAL RESIDENCE (Who o. STATE	ere deceased lived. If institution b. COUNTY	nn: Residence before odmission)
b. CITY OR TOWN (If autside corporate limits, write RURAL and give nearest town)	LENGTH OF STAY IN 16	C. CITY OR TOWN (IF o	Orgheenle	JRAL and give nearest town)
G. NAME OF HOSPITAL IN not in hospital, give street odd OR INSTITUTION	iréss)	d. STREET ADDRESS	of Road	e. IS RESIDENCE ON A FARM? YES NO
NAME OF DECEASED (Type or print) ANNA IE.	NTHZ T	rott	4. DATE Mont	Day Yeor
Fremule Color OR, RACE 7. MARRIED WIDOWED	DIVORCED [B. DATE OF BIRTH Sept. 27, 18	9. AGE (In years last birthday) 9 yrs.	IF UNDER 1 YEAR IF UNDER 24 HR. Months Doys Hours Min.
Oa. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	HO OF BUSINESS OR INDU	STRY 11. BIRTHPLACE (Stole	or foreign country)	12. CITIZEN OF WHAT COUNT
William H. Leo	4-	14. MOTHER'S MAIDEN N	Ponnen	4
S. WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SO: Yes, no, or unknown) (II yes, give wor or dates of service)	CIAL SECURITY NO. 17. 1	NFORMANT /	Bal. Oly	begwille Med.
18. CAUSE OF DEATH [Enler only one couse per line f PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o)	ar (a), (b), and (c).]	a Heart For	iline c	INTERVAL BETWEEN ONSET AND DEATH
526 X DUE TO Conditions, if ony, which)	conduy Edl	neg-Lena	el Facture	- 1 more
gove rise to immediate couse (a), stating the under-lying couse last.	nchettas	is- Bronch	eal asthma	Herele 25 mg
HAVELLESTALLE GITTERS	TRIBUTING TO DEATH BUT	NOT RELATED TO THE TERMIN	NAL DISEASE CONDITION GIVE	EN IN PART I(o) 19. WAS AUPOPSY PERFORMED? YES NO
(IF ETHER, NOTIFY MEDICAL EXAMINER)	BE HOW INJURY OCCURRE	D. (Enter nature of injury in P	ort 1 or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year 20d. INJU While of work	Not while for	ACE OF INJURY (Home, form, ctory, street, office bldg., etc.	20f. (City or town)	(County) (State
21. I certify that I attended the deceased alive an OCOM 9 - 1959	4	1950, to 00	1 - 19 , 1959	that I last saw the decear
ACTUAL SIGNATURE TROMAN E. W	heeler		DORESS (Street, city or town,	
PHYSICIAN'S THOMAS E. WA	HEELER	B	4ch > -	Md
20. BURIAL, CREMATION, 22b. DATE THEREOF REMOVAL (Specify) 10-22-59	Oakla	R CREMATORY	22d. LOCATION (City, town, o	(Stote)
FUNERAL DIRECTOR'S SIGNATURE	ADDRESS Property	11 1961	BY REGISTRAR 24b. REGIS	TRAR'S SIGNATURE

BY GROWING	STUAR OF THE MINARED STATE ORALLY		
	HTARGEO STADERTRED		
	THE COMMISSION OF STREET	三 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	
	AND STREET, ST		
		Variation with the	
		Carlo de Villa de P	
managed strategy residence of the			

Washington.

The S. H. Hines Co.

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18 Item 1 C'CERTIFICATE OF DEATH Rea. Dist. No. 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give negrest town) 1556-2 e. IS RESIDENCE ON A FARM? 8011 Eastern Avenue YES NO TE Month Day Year 19 IF UNDER 1 YEAR IF UNDER 24 HRS 9. AGE (In years lost birthdoy) Months Days 12. CITIZEN OF WHAT COUNTRY? U.S.A. Address Springfield State Hospital Record INTERVAL BETWEEN ONSET AND DEATH alou Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o) 19. WAS AUTOPSY Chronic brain syndrome associated with disturbance of metabolism, PERFORMED? YES NO (County) (Stote) 195 That I last saw the deceased M, from the causes and an the date stated above. ADDRESS (Street, city or town, stole) 22d. LOCATION (City, town, or county) (Stote)

VS A15 (4)

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11266

11285

CERTIFICATE OF DEATH

		_							
1. PLACE OF DEATH o. COUNTY	Carroll		MARYLAND	2. USUAL RESI	Maryland	eased lived. If institut b. COUNTY	_	e before odmission) 1to_City	10
	(If outside corporate lim	its, write	c. LENGTH OF STAY IN 16	c. CITY OR		orporote limits, write I			
RURAL ond give Svkesvi			7yrs. 9 mos.	Ва	ltimore	3 V	101-	U.	
d. NAME OF HOSE	ITAL of not in hospital,	give street		d. STREET A	ADDRESS			e. IS RESIDEN	
OR INSTITUTION	ield State			34	61 Chestr	nut Ave., Ze	one 11	ON A FAR	
3. NAME OF DECEASED (Type or print)	Pali		Windent Vincent	Yeag	OF	0 1 1		16, Yeor	
5. SEX	6. COLOR OR RACE	7. MARI	RIED NEVER MARRIED	8. DATE OF BIRT	н	9. AGE (In years	IF UNDER	YEAR IF UNDER 24	4 HRS
Male	White	WIDOW	ED DIVORCED	Februar	y 4, 1918	3 Jan yrs	Months	Doys Hours A	Min.
100. USUAL OCCUPAT	ION (Give kind of work	done 10b.	KIND OF BUSINESS OR IND			1	12.CITI2	EN OF WHAT COUN	NTRY
Checker	orking life, even if refired)			vland			U.S.A.	
13. FATHER'S NAME					MAIDEN NAME			0,00,110	
Taba W	Vacana				na Mae Roe	374			
John V.	VER IN U. S. ARMED FOI	CES2 14	SOCIAL SECURITY NO	INFORMANT	la mae moe		Iress		
(Yes, no, or unknown)	(If yes, give war or dates of				9 3 17 4 4				
No	-			pringile	era Hosbi	al Records	3		
	EATH [Enter only one co	ouse per li	ne for (o), (b), and (c).]					ONSET AND DEA	ATH
PART I. DI	EATH WAS CAUSED BY: IMMEDIATE CAUSE (RI	neumatic heart	disease				Years	
14.10 X	DUE TO								
Conditions, if	ony, which)	M-	itral stenosis					Years	
gove rise to	immediate (-
couse (o), statin lying couse los		-1							
Schizoph	THER SIGNIFICANT CON renic react	ion,	catatonic type	T NOT RELATED TO	THE TERMINAL DIS	EASE CONDITION GI	VEN IN PART	1(o) 19. WAS AUTO PERFORME YES NO	EUP
O (IF ETHER, NOTIF	VAS UNDERLYING [] IG [] CAUSE OF DEATH FY MEDICAL EXAMINER)	20b, DES	CRIBE HOW INJURY OCCURR	ED. (Enter noture o	of injury in Port I or	Port II of item 18.)			
Y 20c. TIME OF INJU Hour o. m p. m	10	While		LACE OF INJURY (octory, street, office	(Home, form, 20f. e bldg., etc.)	(City or town)	(C	ounty) ((Stote
21. I certify alive an Oct	that I attended the	deceas , 195	ed fram November	11, 1958 h accurred at	10:20AMfr	om the causes at S (Street, city or town	nd an the	at saw the dece	bave
ACTUAL SIGNATURE	raneeres	щ	agro Mun	M.D. Spri				10/16/	59
PHYSICIAN'S NAME (Type)	Francesco	Magro	M.D.	Syke	esville, l	Maryland			
220. BURIAL, CREMAT	ION, 22b. DATE THERE	OF	22c. NAME OF CEMETERY	OR CREMATORY	22d. LC	CATION (City, town,	or county)	(Stote)	
Burial Specif	" Oct.20	/59	Lorraine 1	ark	Woo	dlawn 7,	Md.		
23 FUNERAL DIRECTO	R'S SIGNATURE TO	cact	ADDRESS		24a. REC'D BY RE	GISTRAR 24b. REG	ISTRAR'S SIG	NATURE	
4101 Eam	uneral Din ondson Av				DATIOCT 1 9	159 an	Chan 8. 4	Trans	

(The late of the first of the late of the late of the broken at the broke Colores Vincent 2016-57 A Sangleyna at the Indiana statements. Catherine to the property of the 1-1-1-1 Elected's Logs 20 anner e and the state of t Of a far breat mount blockback of the Park of the Control of the C President Confederation and Confederation of the Co Tell Det. 20/59 Lingual of Park woodlaws 7. Mil. Bundonile Reader averig

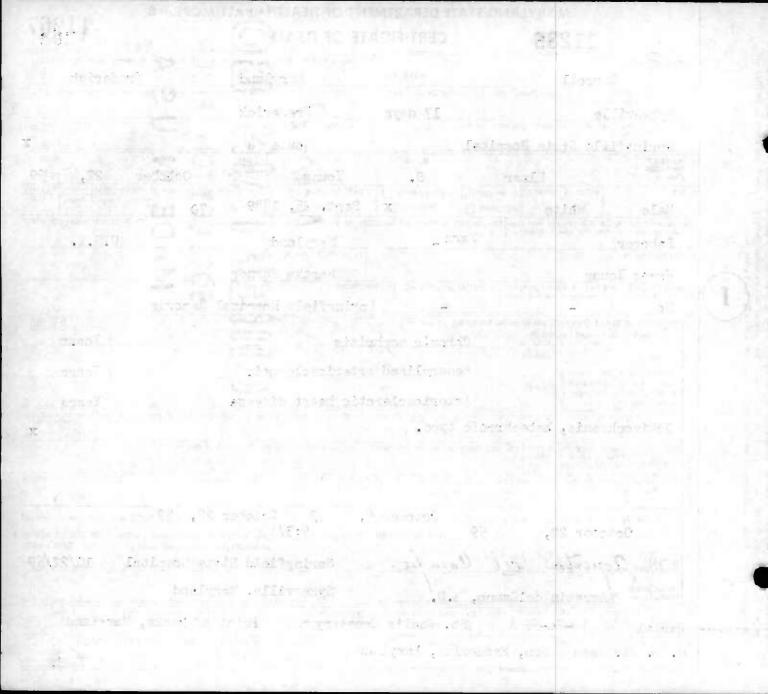
11996 CERTIFICATE OF DEATH 11267

arthur S. Krous

	11200		CERTIFICA	CIE OI DEA			Reg. Di	st. No.		
1. PLACE OF DEATH a. COUNTY C	arroll		MARYLAND	2. USUAL RESIDENCE a. STATE Ma:	(Where deceased ryland	l lived. If institution b. COUNTY		deri		ion)
b. CITY OR TOWN (I RURAL and give no	If autside carporate limearest tawn)	its, write	c. LENGTH OF STAY IN 1b	c. CITY OR TOWN	(If autside carpo	rate limits, write R	URAL and	give near	rest town	n)
Sykesvil			17 days		derick			10%	- 0	2
OR INSTITUTION	TAL (If not in hospitol, eld State I			d. STREET ADDRES	te #L					FARM?
NAME OF		rst	Middle	Last	4. DATE	Man	ith	Day	,	Year
(Type ar print)	Elr	ner	S.	Young	OF DEATH	Octo	her	22		19 59
. SEX				B. DATE OF BIRTH		9. AGE (In years	IF UNDER		-	
Male	White	WIDOW	ED DIVORCED	Sept. 25,	1889	70 yrs.	Months	Days	Haurs	Min.
Da. USUAL OCCUPATION during most of war	ON (Give kind af wark king life, even if retired	dane 10b.	KIND OF BUSINESS OR INDUS	TRY 11. 8IRTHPLACE (S	itate ar foreign co	iuntry)		IZEN OF		OUNTR
Laborer			Farm_	Maryla				U.S.	A.	
3. FATHER'S NAME				14. MOTHER'S MAID	EN NAME					
James Yo	ung			Martha	Warner					
	R IN U. S. ARMED FOI (If yes, give war or dates of		SOCIAL SECURITY NO. IN	FORMANT		Add	ress			
No	(ii yes, give war or dates or	ser vice)	- 9	pringfield	Hospita	Record	St.			
-	ATH Enter only one of	ouse per li	ne far (a), (b), and (c).]	Dr Trigge Brack	11000200	2 0002 0		LINTE	RVAL 8E	TWFFN
	TH WAS CAUSED BY:							ONSE	ET AND	DEATH
1/0-	IMMEDIATE CAUSE (Chronic nephi	ritis				Ye	ars	
420.	O DUE TO									
Canditians, if o)(Generalized a	arterioscle	rosis			Ye	ears	
cause (a), stating lying cause last.	the under-		Arteriosclero	otic heart	disease			Ye	ars	
	renia, heb		nic type.	NOT RELATED TO THE T	ERMINAL DISEASE	CONDITION GIV	'EN IN PAR		PERFO	
20a. ACCIDENT WA OR CONTRIBUTING (IF EITHER, NOTIFY	AS UNDERLYING CAUSE OF DEATH MEDICAL EXAMINER)	20b. DES	CRISE HOW INJURY OCCURRED	. (Enter noture of injury	y in Part I ar Part	II af item 18.)				
20c. TIME OF INJUR Hour a. m. p. m.	RY Manth, Day, Ye	ar 20d, li While at war	Nat while fact	CE OF INJURY (Hame, tory, street, affice bldg.	farm, 20f. (City , etc.)	ar tawn)	(6	County)		(Stat
actual signature	ober 22,	19_ Lel	ed fram October 5	accurred at 9:3	7A _M , fram ADDRESS (St	the causes an reet, city ar tawn, cate Hosp	d an the	ist saw e date	stated	deceased abavers significant
	Agustin de									
Burial (Specify)	10-26-59		St. Paul's C		Point	t of Rock	or county)	aryl	and	e)
M. R. Etch	's SIGNATURE Son	, Fre	ADDRESS Maryla	nd 240.	REC'D BY REGIST		STRAR'S SIG			15-45

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 Pages 1 and 2 should be filed with he funeral director, TO HOSPITAL OR ATTENDING PRISICIARY. THE CONTROLL OF A TENDING PRISICIAL OR ATTENDING PRISICIAL OF THE ACTION OF THE PRISICIAL OF THE PRISICIA

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24 hou	Poges	oge 5 r	e poge	
within	. Give	PM3. P	mit. Fi	
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te shou	in pe	fice alc	os o po	
certifica	pending	ner's Of	e used	
2: This	word "	Exomir	hould b	
AMINE	ng the	Medical	oge 3 s	
CAL EX	le, writi	Chief /	CTOR: F	
MEDIC	ertifica	off of	FIRE	31.
DEPUTY	te the c	rwards	UNE	remove
5 TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours ofter death. If any delay is necessory, please e	CO	fo	TO FUNE: TRECTOR; Page 3 should be used as o buriol-transit permit. File pages 1 and 2 with the registrar prior to burial, cremoit	o
VS	. A	15	ME(5)

1	1128 EDICAL EXAMINER'S CERTIFICATE OF DEATH Reg. Dist. No. 1268						
	1. [PLACE OF DEATH COUNTY CARPOIL MARYLAND	2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) o. STATE b. COUNTY				
	b	o. CITY OR TOWN (If outside corporate limits, write RURAL on dive necrest lows) C. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If autside corporate limits, write RURAL and give nearest town)				
	0	d. NAME OF HOSPITAL OR INSTITUTION (If Not in haspital, give street address)	d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES \(\) NO \(\)				
	-1	NAME OF DECEASED Citype or print) First Middle Z	MMERMAN DATE Month Day Year OF DEATH OCK 19 V9				
	5. \$	Formale White WIDOWED DIVORCED	8. DATE OF BIRTH 9. AGE (In years left UNDER 14 EAR IF UNDER 24 HBS. Solution of the left of the l				
	0	USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR INDUS during most of working life, even if refiredy HOUSEWORK WATTOMAC	STRY 11. BIRTHPLACE (State or foreign country) 12. CITIZEN, OF WHAT COUNTRY?				
		Howard L. Andnews	Margaret German				
		WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give was or defea of service) (If yes, give was or defea of service)	eRay Nichols Hagerstown Md.				
		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 23/X DUE TO	ASEULAR ACEIDEN				
		Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (b) (b) (c)					
7	CERTIFICATION		NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPSY PERFORMED? YES NO				
		20g. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.	(Enter nature of injury in Part I or Part II of item 18.)				
	MEDICAL	20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e. PU While Not while at work at work at work	ACE OF INJURY (Hame, farm, tory, street, affice bldg., etc.) (City or town) (County) (Slate)				
		21. I certify that I taok charge af the remains described above, held an Autopsy , Inspection , Inquiry , and find that death resulted from: Natural causes , Accident , Suicide , Hamicide , Undetermined cause .					
		ACTUAL SIGNATURE SELULS J. March	M.D. CHIEF MEDICAL EXAMINER [] DATE SIGNED ASSISTANT MEDICAL EXAMINER []				
2		EXAMINER'S TAMES TMARSH	DEPUTY MEDICAL EXAMINER A				
	Z	BURNAL (SPEMATION, 22b-DATE THEREOF 22c. NAME OF CEMETERY OF	KIS Highered - Howard Co. He				
	"35	Aunard Phipton Hampstead	Md DATE OCT 2 0 '59 Cithur S. Hrang				

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

FORT Manager	MITARE TO STADISTING	DICAL EXAMINATE	W8511
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	CONTRACTOR OF THE SECOND		
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	September 1 Septem	DAKA DAK	